PEAKONE administration

HRA ENROLLMENT FORM

Please return this completed form to your HR Department

Please PRINT Clearly

Employer Troy School District				Plan Effective Date
Employee's Name (Last, First MI)		Date of Birth		Social Security Number:
Employee's Home Address	City	State	Zip	Home Phone
Employee Email Address				

Dependent Information	**First Name**	**Last Name**	**Date of Birth**	**Social Security Number**

Reimbursement Sections:	**Enrollment Type (Please check one)**
Health Reimbursement Arrangement (HRA):	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

The IRS regulation states four conditions. 1.) Any expenses you incur must be within the plan year. 2.) Any expenses you incur must not be covered by any other source such as insurance. 3.) You must provide proper documentation to receive payment. 4.) You cannot change your enrollment during the plan year unless there is a specific Change of Status and your employer allows such changes. Please see the Summary Plan Description. **Prior to each plan year, I will be offered the opportunity to change my benefit enrollment for the following plan year.**

Signature: X_____ **Date:** _____