HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ENROLLMENT FORM

Complete and return to your employer

Group Information

Group Name:______________________ **Further Group Number:**______________________

Location Name (if applicable): ______________________

Employee Information

SSN#: ______________________ **Primary Phone:** ______________________

Last Name: ______________________ **First Name:** ______________________ **Middle Initial** ________

Street Address: ______________________

City: ______________________ **State:** ______________ **Zip Code:** ______________

Email Address: ______________________ **Date of Birth:** _____/______/__________

Account Information

Health Reimbursement Account:

Effective Date: ______________________ **(To be provided by Group Contact)**

Health Plan Coverage:

- ☐ Single
- ☐ EE + spouse
- ☐ EE + child
- ☐ EE + children
- ☐ Family

HRA EE Pays First Threshold Amount: ______________________ **(if applicable)**

Dependent(s) on Health Plan

Name	Effective Date	Date of Birth	Relationship

Employee Signature

I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the Plan Year will be forfeited.

Signature: ______________________ **Date:** ______________

Save time: submit this information online. Questions? Call Group Leader Services at 1-888-460-4013.

Submit online:
Log into your account at hellofurther.com

Send via secured email only:
further.documents@hellofurther.com

Fax to:
866-231-0214

Mail to:
P.O. Box 64193
St. Paul, MN 55164-0193

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