

Health Reimbursement Arrangement (HRA) Participant Enrollment Form

Employer Name _____

Applicant Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Address _____ City _____ State _____ Zip _____

Home or Cell Phone _____ Work Phone _____ Email _____

HRA Benefit Name _____ HRA Effective Date (mm/dd/yyyy) _____

Coverage Tier: Self Only Self & Spouse Self & Children Family

Medicare Secondary Payor (MSP) Reporting Information

Are you a Medicare beneficiary: Yes No If Yes, provide Medicare HICN here: _____

Payment Information

Reimbursement will be made via the mySourceCard® or by Electronic Funds Transfer (Direct Deposit) into your checking or savings account. For direct deposit, please provide bank account information below -OR- attach a voided check.

I choose the mySourceCard® for my payment method.

I understand that the mySourceCard® is restricted to certain merchant categories and is not accepted at all Mastercard® acceptance locations. I understand that I may not obtain a cash advance with the mySourceCard® at any merchant, bank or ATM. I understand that the Summit Card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which I participate. If the mySourceCard® is issued pursuant to Employer Plans and I use the Card for an expense that is not a Qualified Expense I am indebted to my Employer and must repay the full amount of the non-qualified expense. I agree to save all invoices and receipts related to any expenses paid with the mySourceCard®; upon request I must submit these documents for review by DataPath Administrative Services. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and I will be required to remit payment to my Employer. Payment may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, a post-tax deduction from my paycheck, or other options established by my employer.

I choose Direct Deposit for my payment method.

Routing Transit Number

(All nine boxes must be filled)

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Account Number

(Include hyphens, but not spaces and special symbols)

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Signature _____ Date (mm/dd/yyyy) _____

**** IMPORTANT: If your spouse or any of your dependents are covered by the health insurance plan listed on the reverse side please complete the form below for each person (besides yourself) who is covered by the HRA plan.**

Dependent #1

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

Dependent #2

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

Dependent #3

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

Dependent #4

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

If you have more than four dependents covered by this health insurance plan, please provide the above information about each person on a separate sheet of paper and attach to this form.

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