SelectAccount℠

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ENROLLMENT FORM

Complete and return to your employer

Group Information

Group Name:____________________ **SelectAccount 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 (651) 662-2320 or 1-888-460-4013**.**

Submit online:
Log into your account at
www.SelectAccount.com

Send via secured email only:
SelectAccount.documents
@SelectAccount.com

Fax to:
651-662-7247
866-231-0214

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

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