FURTHER℠

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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:	**Send via secured email only:**	**Fax to:**	**Mail to:**
Log into your account at hellofurther.com	further.documents@hellofurther.com	866-231-0214	P.O. Box 64193 St. Paul, MN 55164-0193