STERLING HSA®

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HRA Enrollment Form

Employee Information *(please print clearly)*

Employer Name: _____

Social Security #: _____ Date of Birth: _____

Employee's First Name: _____ Middle Initial: ____ Last Name: _____

Employee's Home Address: _____

City: _____ State: _____ Zip: _____

Employee's Home Phone: _____ Email: _____

☐ Male ☐ Female Type of Coverage: ☐ Single ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Dependent Information

FIRST NAME	LAST NAME	SSN #	BIRTH DATE	RELATIONSHIP (SPOUSE or DEPENDENT)	GENDER (M or F)	STUDENT (Y or N)

I acknowledge and agree to these IRS required conditions for reimbursement. The IRS regulation states four conditions. 1) Any expenses you incur must be within the plan year; 2) Expenses you incur may not be reimbursed by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your election during the plan year unless there is a specific change of status and your employer allows such changes.

Signature: _____ Date: _____

Employer Information *(Employer to complete this section.)*

Plan Effective Date: _____
Month Date Year

HRA Annual Total $ _____ HRA Annual Total per Family Member $ _____

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