

Use this form if your enrollment information does not come to SelectAccount from your health plan administrator.

EMPLOYER NAME:			
NAME OF PERSON SUBMITTING INFORMATION:		PHONE NUMBER:	
SINGLE HEALTH PLAN DEDUCTIBLE:	SINGLE HRA PLAN YR AMT:	FAMILY HEALTH PLAN DEDUCTIBLE:	FAMILY HRA PLAN YEAR AMOUNT:
EMPLOYEE'S NAME: LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
EFFECTIVE DATE:	HRA AMOUNT:		DAYTIME PHONE
COVERAGE TYPE: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY			
DEPENDENT FIRST/LAST NAME	EFFECTIVE DATE	DOB	RELATIONSHIP TO EMPLOYEE
EMPLOYEE'S NAME: LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
EFFECTIVE DATE:	HRA AMOUNT:		DAYTIME PHONE
COVERAGE TYPE: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY			
DEPENDENT FIRST/LAST NAME	EFFECTIVE DATE	DOB	RELATIONSHIP TO EMPLOYEE
PLEASE NOTE:			
<p>This form is being provided to you for your convenience. If this information is available in another format, please feel free to forward the information to SelectAccount in that version.</p>			
EMPLOYER'S SIGNATURE: _____		DATE: _____	