gente
Employee Benefits and HR Solutions
Strong relationships start here

HRA ENROLLMENT FORM

122 Parish Drive, Wayne, NJ 07470

* REQUIRED FIELDS *			
*Employer Name:			
*Employee Last Name, First Name:			*Social Security #:
*Home address (include apt#):			*Date of Birth:
*City	*State	*Zip	*Date of Hire:
*Email Address:			Phone Number:
*Marital Status: S / M / D / W			*Gender: M/F

*Is this person now or has this person ever been enrolled in Medicare? Y/N: _____
*If yes, you must provide the Medicare identification number (HICN) _____

DEPENDENTS TO BE COVERED UNDER THE HRA

Relationship (Spouse or dependent)	Name	Gender M/F	SSN	DOB	Currently/ever enrolled in Medicare
					Y/N_____ Claim#/HICN_____
					Y/N_____ Claim#/HICN_____
					Y/N_____ Claim#/HICN_____
					Y/N_____ Claim#/HICN_____
					Y/N_____ Claim#/HICN_____

AUTHORIZATION OR WAIVER OF PARTICIPATION

☐ I elect to participate in the *gente* HRA plan ☐ I ***do not*** elect to participate in the *gente* HRA plan

Employee Signature: _____ **Date:** _____

Please return this form to your Benefits/Human Resources administrator

---------- **FOR EMPLOYER USE ONLY** ----------

*** Required Fields / Must be completed for enrollment to be processed**

***First Day of Coverage** ____/____/_____ **Name of Health Plan** _____

***HRA Amount $**_____ ***Health Plan Tier (check one) ___Single ___Employee/Spouse ___Parent/Child ___Family**

Employer Representative Signature _____

Note: Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2001 (MMSEA) requires gente to report certain HRA enrollment data to the Centers for Medicare & Medicaid Services.
*Note: Partners, sole proprietors, owners of LLC and 2% or more owners of sub chapter S corporation are not permitted to participate in an HRA program.

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