Progressive Benefit Solutions, LLC

Health Reimbursement Arrangement Enrollment / Change Form

Company Name				
Last Name	**First Name**	**MI**	**Social Security Number**	
Home Address	**City**	**State**	**Zip**	
Daytime Phone ( )	**Home Phone** ( )	**Date of Hire**	**Date of Birth**	**E-mail**

Enrollment Status:
Check One:
☐ Single ☐ EE+SP ☐ EE+CH ☐ Family

Check One:
☐ New Hire ☐ Open Enrollment
☐ Change in Status
Date of Event: _____

You may be permitted to change your HRA election if you have a qualifying status change. To make a change, you must report the change within **30 days** of the event to Human Resources. All changes are subject to Plan Administrator approval.

Only expenses incurred on or after the date of your qualifying status change are eligible for reimbursement under the new election.

If status change, indicate reason:

☐ Change in marital status
☐ Birth/adoption/placement for adoption of child
☐ Death of a dependent
☐ Change in dependent's eligibility
☐ You/your dependent becomes eligible for Medicare or Medicaid
☐ Change in residence/workplace that affects eligibility of healthcare benefits
☐ Leave without pay due to military deployment
☐ Change in your/spouses employment status that affects eligibility of health care benefits.

Employee Acknowledgements

EMPLOYEE ACKNOWLEDGEMENTS

I acknowledge that:

- All claims submitted for reimbursement are subject to substantiation requirements and I will be required to retain all itemized receipts/statements and offer them as proof of eligibility when requested by the Plan Administrator, Claims Administrator (Progressive Benefit Solutions, LLC (PBS)) or the IRS.
- I will not seek reimbursement of claims through my health reimbursement arrangement when they are eligible for reimbursement elsewhere.
- I agree to use the benefits debit card for eligible expenses only.
- I understand the benefits debit card will be inactivated if I do not comply with the provisions of the Plan/card or upon termination of employment.
- I am responsible for any fees associated with the benefits debit card, not otherwise paid for by my employer.

Employee Signature: _____ **Date**: _____

RETURN THIS COMPLETED FORM TO HUMAN RESOURCES