HRA Enrollment Form
Complete for primary and each dependent

ALL Provided Employee Fields Marked * are REQUIRED			
Employer*		☐	**Check to indicate changes in your personal information**
Employee Last Name*	**Employee First Name***		**Middle Initial**
Social Security Number*			**Date of Birth*** - -
Home Address*	**City***	**State***	**Zip Code***
Email Address	**Main Phone***	**Secondary Phone**	

Please see the HRA Employee Information Packet for the following information:

New Hire Pro-Rating

Plan Maximum Limit

Deductible Maximum

Employer Reimbursement Maximum

Deductible

Employee Maximum

Contributions

Rollover and Filing Limits

Clarification of HRA Benefits

Please indicate who the Employer HRA Benefits and funding amount based on the Plan details (select one)	
Employee	$ 2,000.00
Family	$ 2,000.00
Employee + Spouse	$ 2,000.00
Employee + Child	$ 2,000.00
Other:	$ 2,000.00
Expected Contribution (see prorate details)	$ 2,000.00

The maximum annual Employer Contribution is $2,000

Please Submit All Forms to:		
Eric Herzog		
317.923.3681	eherzog@whitewatervalley.org	1100 West 42nd Stret STE 210 Indianapolis, IN 46208

I Understand and Agree that:
By completing and signing this form, I accept responsibility for all transactions incurred within the Plan Year by any of dependents I add to my Employer Sponsored Plan. Form updated 9/8/2023.

Employee Signature*_____Date*_____ - -