Rocky Mountain Administrators *Names you know, experience you can trust*

HEALTH REIMBURSEMENT ACCOUNT ENROLLMENT FORM

Employer	Group Number	Effective Date

Employee's First Name	M.I.	Last Name	Date of Birth	Sex (M/F)

Employee Mailing Address	City, State, Zip Code	Phone Number

Hire Date	Social Security Number	Number of Children

Marital Status: Single___Married___Divorced ___

Coverage Elected: Single [ ] w/Spouse [ ] w/Children [ ] Family [ ]

Complete the following section for any dependents that you are electing coverage for:

Spouses Name	Date of Birth	M/F	Social Security Number

Dependent Name (Please list)	Date of Birth	M/F	Social Security Number

Signature of Employee **Date**

If you and/or any dependent are NOT enrolling, please complete this waiver section.

After careful consideration I have chosen:

_____Not to enroll myself and my dependent in the plan

_____Not to enroll my spouse in the plan

_____Not to enroll my children in the plan

Waver of Coverage:

Signature of Employee **Date**

Rocky Mountain Administrators

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