MCMUNN ASSOCIATES INC.
HEALTH REIMBURSEMENT ARRANGEMENT
ENROLLMENT/CHANGE/TERMINATION FORM

(Please Print)

1. Name:_____ Effective Date_____
(Last) (First) (MI)
Marital Status:_____ Date of Hire_____ Soc. Sec. _____ - ____ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____Home/Cell Phone _____
I prefer to be contacted regarding my HRA Account via Email ____, Wk Ph____, Hm/Cell Ph_____, 1st Class Mail_____

2. Action to Be Taken:
[ ]Enroll in HRA Plan [ ]Change In Covered Dependents

3. I select the following coverage option:
[ ] Employee Only [ ]Employee & Spouse [ ]Employee & Child [ ]Employee & Family

4. List eligible family members for Health Reimbursement Arrangement coverage:

Last Name	First Name	Relationship (Self/Spouse/Child)	M/F	SS#	Date of Birth	Medicare Eligible
Employee		*Self*				Y or N
Dependent						Y or N
Dependent						Y or N
Dependent						Y or N
Dependent						Y or N

Please Note: You must complete a new Enrollment Form within 30 days of qualifying event to add eligible family members.

5. **Choose One Option:**

☐ **General Purpose HRA** - By checking this box I acknowledge that I am eligible to receive all IRC 213(d) benefits being offered by this HRA plan. I will not make a contribution to an HSA for this calendar year.

☐ **Limited HRA Plan for Employees with active Health Savings Accounts (HSAs)** - By checking this box I choose only Limited Purpose HRA benefits and voluntarily waive the HRA plan's IRC 213(d) benefits except reimbursement of dental, vision, preventive care, permitted insurance and permitted coverage, as allowed by the HRA **AND / OR** I voluntarily waive reimbursement for IRC 213(d) benefits as provided by the HRA Plan before the HSA Plan deductible of $_____ has been satisfied.

6. Authorization and Agreement

I have read the Health Reimbursement Arrangement Summary Plan Description and agree to abide by the terms of the Plan Document. I recognize I must submit third party substantiation/EOB and a Reimbursement Request Form to the Plan's Administrator for the reimbursement of qualified expenses, as determined by the Plan Administrator. I recognize that any expenses I submit for reimbursement must not be covered by any other source such as insurance. I understand that I will have three months in which to submit qualified expenses following the close of a Plan Year, or upon termination of participation.

Employee's Signature _____ Date: _____

MCMUNN ASSOCIATES INC.
HEALTH REIMBURSEMENT ARRANGEMENT
REIMBURSEMENT REQUEST FORM

PERSONAL DATA (Please Print)

Name	SS# (Last four digits only) XXX-XX-
Home Address	Address Change: ☐Yes ☐No
City	State / Zip
Phone: Work ( ) Home/Cell ( )	Email: I prefer to be contacted by Email, Wk Ph, Hm Ph, Mail (*circle one*)

You must provide a receipt showing the date of service, amount of service, description of service, name of service provider, and name of patient or other evidence the expenses were incurred (such as an EOB from your Insurance Provider). If this form is incomplete your claim could be denied. Print or type the information requested, then sign and date the form.

	Name of Medical Provider (Doctor, Pharmacy, etc.)	Date(s) of Service (or Period of Coverage)*	Patient Name	Relationship (Self, Spouse, Child)	Amount that is your responsibility	General Medical Expense Description. (Must Attach Prescription for OTC Medication.)
1					$	
2					$	
3					$	
4					$	
5					$	
6					$	
7					$	
8					$	
9					$	
10					$	
		Total Medical Amount Requested →				$

Please arrange documentation in order listed above

***Claims for future services will not be accepted**

I request payment from my **Health Reimbursement Arrangement (HRA)** account as indicated above for the expenses listed. I certify that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while I was enrolled in the employer's HRA with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify that these expenses will not be claimed as an income tax deduction. I certify that I am enrolled in the ACA required minimum essential health insurance coverage. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents.

☐ **I am funding an HSA for this Plan Year** ☐ **I am NOT funding an HSA for this Plan Year**

I will not request any item that would disqualify my HSA.

Employee Signature_____ Date_____

SUBMIT YOUR COMPLETED CLAIM FORM TO:

MCMUNN ASSOCIATES INC.
900 HADDON AVE STE 302
COLLINGSWOOD, NJ 08108
Fax: (856) 753-9393