



HRA Employee Eligibility Form

** This form must be completed in its entirety to comply with Federal Regulations. **

Employer Name: City of Kettering		Dept:	
Employee Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth:	Social Security #:		
Street:	City:	State:	Zip:
Date of Hire:	HRA Eligibility Date:	Termination/Benefit End Date:	

Benefit Information

HRA Benefit Amount:	
Type of Coverage:	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family

Dependents Covered by HRA

First Name	Last Name	Social Security #	Date of Birth	Relationship to Employee

Medicare Eligibility

Is the employee or any dependent enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare Participant Name:	Medicare Health Insurance Claim Number (HICN):
Effective date of eligibility/entitlement <input type="checkbox"/> Part A _____ <input type="checkbox"/> Part B _____ <input type="checkbox"/> Part A & B _____ <input type="checkbox"/> Part D _____	Reason for Medicare eligibility/entitlement <input type="checkbox"/> Age <input type="checkbox"/> End-Stage Renal Disease (ESRD) <input type="checkbox"/> Disability <input type="checkbox"/> Disability and current ESRD

Employee Signature

Date

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