



Health Reimbursement Account (HRA) Enrollment Form

Employer Name: **Douglas County**

Effective Date: _____

Participant Name _____
Last First MI

Address _____
Street City State Zip

Social Security Number _____ Phone _____

I would like reimbursements by:

- Benny Card
- EasyPay
- Manual Claims

***Choose only one reimbursement option and fill out either the Benny Card Enrollment Form OR the EasyPay Enrollment Form. No enrollment form needed for manual claims.**

Dependents:

Spouse Name _____
Last First MI

Child Name _____
Last First MI

Child Name _____
Last First MI

Child Name _____
Last First MI

Child Name _____
Last First MI

Total HRA amount to be contributed per year: Single (\$900) Family (\$1800)

I hereby certify the above information to be correct and true to the best of my knowledge and that the children or dependent on whom I will be claiming dependent expenses either reside with me in a parent-child relationship or are legally dependent on me for their support.

Signature

Date

Please return this form to your Payroll or Human Resources Department.