

# CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION HRA ENROLLMENT / TERMINATION FORM

DATE OF HIRE: \_\_\_ / \_\_\_ / \_\_\_

EFFECTIVE DATE OF COVERAGE: \_\_\_ / \_\_\_ / \_\_\_

CONTRIBUTION: \$ \_\_\_\_\_

TERMINATION DATE: \_\_\_ / \_\_\_ / \_\_\_

COVERAGE STATUS:     ACTIVE                       COBRA

## PERSONAL INFORMATION

<b>NAME:</b>	LAST	FIRST	MIDDLE	<b>HOME PHONE NUMBER:</b>
<b>ADDRESS:</b>	STREET	APARTMENT #	CITY	STATE      ZIP
<b>SOCIAL SECURITY #</b>	<b>DATE OF BIRTH</b>		<b>SEX</b>	
___ / ___ / ___	___ / ___ / ___		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
<b>MARITAL STATUS:</b>	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOW <input type="checkbox"/> SEPARATED

### LIST THOSE DEPENDENTS (SPOUSE & CHILD[REN]) YOU WISH TO COVER UNDER THIS PLAN:

- DEPENDENT(S)     ADD – EFFECTIVE DATE \_\_\_ / \_\_\_ / \_\_\_     SPOUSE     CHILD(REN)     DEPENDENT IS DISABLED  
 TERMINATE - EFFECTIVE DATE: \_\_\_ / \_\_\_ / \_\_\_      (DOCUMENTATION ATTACHED)

LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY #	FULL TIME STUDENT (TO AGE 23) SCHOOL NAME (DOCUMENTATION ATTACHED)

## CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## FOR HR USE ONLY

PROCESSED BY: \_\_\_\_\_ DATE \_\_\_\_\_

**CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION  
HRA REIMBURSEMENT CLAIM FORM**

<b>PERSONAL INFORMATION</b>					
NAME:	LAST	FIRST	MIDDLE	HOME PHONE NUMBER:	
ADDRESS:	STREET	APARTMENT #	CITY	STATE	ZIP
SOCIAL SECURITY #                                    /                                    /					

**Instructions**

1. FOR HEALTH CARE EXPENSE CLAIMS THAT WERE SUBMITTED TO AN INSURANCE COMPANY, ATTACH COPIES OF THE EXPLANATION OF BENEFITS (EOB) ISSUED BY THE HEALTH PLAN / OR INSURANCE COMPANY AND / OR PAYMENT FORMS TO ESTABLISH AMOUNTS NOT PAID BUT ELIGIBLE FOR REIMBURSEMENT UNDER THE HRA.
  
2. SUBMIT THIS FORM TO:     INSURANCE DESIGN ADMINISTRATORS (IDA)  
   P.O. Box 690  
   OAKLAND, NJ 07436  
   CUSTOMER SERVICE # - 1-800-225-1345  
   FAX # - 1-201-337-1391

<b>EXPENSES</b>			
PARTICIPANT NAME	DATE EXPENSES INCURRED	REASON FOR PAYMENT**	AMOUNT PAID
1.			
2.			
3.			
4.			
<b>TOTAL AMOUNT</b>			<b>\$</b>

\*\* USE THE FOLLOWING LETTER DESIGNATIONS FOR "REASON FOR PAYMENT":

A. REPRESENTS AMOUNT(S) OF HEALTH CARE EXPENSE(S) APPLIED TO A DEDUCTIBLE(S).

<b>EMPLOYEE CERTIFICATION AND SIGNATURE</b>	
<p>I CERTIFY THAT ALL ITEMS REQUESTED TO BE REIMBURSED COMPLY WITH CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION'S HRA AND SUCH ITEMS HAVE NOT AND WILL NOT BE COVERED BY ANY OTHER HEALTH PLAN OR PROGRAM OF ANY EMPLOYER OR OTHER PERSON. CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION DOES NOT ACCEPT RESPONSIBILITY FOR DIRECT PAYMENT TO ANY INDIVIDUALS OTHER THAN THE EMPLOYEE.</p>	
SIGNATURE _____	DATE _____