FORM CUT INDUSTRIES
HRA ENROLLMENT / TERMINATION FORM

DATE OF HIRE: ____ / ____ / ____ **EFFECTIVE DATE OF COVERAGE:** ____ / ____ / ____

MONTHLY CONTRIBUTION: $ _____ **TERMINATION DATE:** ____ / ____ / _____

COVERAGE STATUS: ☐ ACTIVE ☐ COBRA

PERSONAL INFORMATION

NAME: LAST FIRST MIDDLE	**HOME PHONE NUMBER:**

ADDRESS: STREET APARTMENT # CITY STATE ZIP

SOCIAL SECURITY #	**DATE OF BIRTH**	**SEX**
_____/_____/_____	_____/_____/_____	☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ 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_____

FORM CUT INDUSTRIES
HRA REIMBURSEMENT CLAIM FORM

PERSONAL INFORMATION

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

EXPENSES

PARTICIPANT NAME	DATE EXPENSES INCURRED	REASON FOR PAYMENT**	AMOUNT PAID
1.			
2.			
3.			
4.			
TOTAL AMOUNT			**$**

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

A. REPRESENTS AMOUNT(S) OF HEALTH CARE EXPENSE(S) APPLIED TO THE IN-NETWORK CALENDAR DEDUCTIBLE(S) OF THE MEDICAL PLAN.

EMPLOYEE CERTIFICATION AND SIGNATURE

I CERTIFY THAT ALL ITEMS REQUESTED TO BE REIMBURSED COMPLY WITH **FORM CUT INDUSTRIES'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. **FORM CUT INDUSTRIES** DOES NOT ACCEPT RESPONSIBILITY FOR DIRECT PAYMENT TO ANY INDIVIDUALS OTHER THAN THE EMPLOYEE.

SIGNATURE_____

DATE_____