

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	
____ / ____ / ____	____ / ____ / ____		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
MARITAL STATUS:	<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 _____

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 _____