FP DUFFY INC.
HRA ENROLLMENT / TERMINATION FORM

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

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_____

F P DUFFY INC.
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 A DEDUCTIBLE .

EMPLOYEE CERTIFICATION AND SIGNATURE

I CERTIFY THAT ALL ITEMS REQUESTED TO BE REIMBURSED COMPLY WITH **CLIENT** HRA AND SUCH ITEMS HAVE NOT AND WILL NOT BE COVERED BY ANY OTHER HEALTH PLAN OR PROGRAM OF **ANY** EMPLOYER OR OTHER PERSON. **CLIENT** DOES NOT ACCEPT RESPONSIBILITY FOR DIRECT PAYMENT TO ANY INDIVIDUALS OTHER THAN THE EMPLOYEE.

SIGNATURE_____ DATE_____