# FRANK D. RIGGIO COMPANY, 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_____

# FRANK D. RIGGIO COMPANY, 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(S).

### 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_____