

# MULHERN BELTING 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 \_\_\_\_\_

## MULHERN BELTING 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.			
<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).

### EMPLOYEE CERTIFICATION AND SIGNATURE

I Certify That All Items Requested to be Reimbursed Comply With **MULHERN BELTING'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. **MULHERN BELTING** Does Not Accept Responsibility For Direct Payment To any Individuals Other Than The Employee.

Signature \_\_\_\_\_ Date \_\_\_\_\_