

TELEMETRICS, INC.
HRA ENROLLMENT / TERMINATION FORM

DATE OF HIRE: ___ / ___ / ___

EFFECTIVE DATE OF COVERAGE: ___ / ___ / ___

CONTRIBUTION: \$ _____

TERMINATION DATE: ___ / ___ / ___

COVERAGE STATUS: ACTIVE COBRA

PERSONAL INFORMATION

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 _____

TELEMETRICS, 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 THE DEDUCTIBLE(S).			

EMPLOYEE CERTIFICATION AND SIGNATURE	
<p>I CERTIFY THAT ALL ITEMS REQUESTED TO BE REIMBURSED COMPLY WITH TELEMETRICS, INC.'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. TELEMETRICS, INC. DOES NOT ACCEPT RESPONSIBILITY FOR DIRECT PAYMENT TO ANY INDIVIDUALS OTHER THAN THE EMPLOYEE.</p>	
SIGNATURE _____	DATE _____