77 Monroe Center NW
Suite 1100
Grand Rapids, MI 49503
Fax: 616-454-6090

Flex Administrators, Inc.

HRA/MRA ENROLLMENT FORM
EMPLOYEE INFORMATION DATA GATHERING FORM

EMPLOYER NAME: _____

PLEASE PRINT CLEARLY – All Data Required (except HICN if not applicable).

EMPLOYEE NAME: _____

EMPLOYEE ADDRESS: _____

CITY/STATE/ZIP: _____

EMPLOYEE SSN: _____/_____/_____ EMPLOYEE HICN: _____

DATE OF BIRTH: _____/_____/____ GENDER: _____ COVERAGE EFFECTIVE DATE: _____/_____/_____

COVERAGE TYPE: _____ COVERAGE TIER: _____

DEPENDENT INFORMATION:

Relationship to Employee (Spouse, Child, Step-Child, etc…)	Legal Name First and Last Name Only	SS#	Date of Birth	Gender	HICN (If Medicare Recipient)
			___/___/___		
			___/___/___		
			___/___/___		
			___/___/___		
			___/___/___		
			___/___/___		
			___/___/___		

Authorization to Use/Disclose Health Information

I authorize the use or disclosure of my individually identifiable health information by or to my spouse, any health care provider, any insurer or claims administrator, or any other entity providing services in connection with the Plan in order to process my enrollment in the Plan or to process any claim for my Plan benefits. This authorization is effective until the date I terminate participation. Further, I have read and I understand the following: (1) I may revoke this authorization at any time before its expiration date by notifying Employer in writing, but the revocation will not have any effect on any actions the Plan took before it received the revocation; (2) I may see and copy the information described in this authorization if I ask for it; (3) I am not required to sign this authorization to receive my health care benefits (enrollment, treatment, or payment); and (4) The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

_____ _____

Employee Signature Date Spouse Signature Date