Clarity | BENEFIT SOLUTIONS™

HEALTH REIMBURSEMENT ACCOUNT ENROLLMENT FORM

PLEASE COMPLETE THIS FORM AND SUBMIT TO YOUR EMPLOYER

Company Name: _____

Last Name _____ **First Name** _____

Social Security Number _____ **Date of Hire** _____

Date of Birth _____ **Effective Date:**_____

Address _____ **City** _____

State_____ **Zip** _____ **Phone** (____) _____

☐ **(Check Here if Mobile Number)**

E-mail Address

_____

Coverage Type: **Single** _____ **Husband/Spouse**_____ **Parent/Child**_____ **Family**_____

Dependent Information

Please provide your spouse and/or dependent information.

	Dependent Name	Relationship	SSN	DOB	Issue Card
1	_____	_____	_____	_____	☐
2	_____	_____	_____	_____	☐
3	_____	_____	_____	_____	☐
4	_____	_____	_____	_____	☐
5	_____	_____	_____	_____	☐

Employee Signature_____Date_____

For Employer Use Only

Effective Date: _____

**Annual plan limits are available at claritybenefitsolutions.com/resources/plan-limits.*