❑ **CHANGE EE INFO**

HRA ENROLLMENT FORM

Date: _____

EMPLOYEE INFORMATION	EMPLOYMENT / COVERAGE INFORMATION
Employee Name: _____	_____
Street Address _____	**Please fill out Company Name & Location Above**
City / State / Zip: _____	Date of Hire: _____
SS #: _____	**Effective Date of Coverage:**
Date of Birth: _____ **Gender:** ❑ **M** ❑ **F**	
Marital Status: ❑ Single ❑ Married ❑ Divorced w/Court Order	Health Plan + HRA:_____
Primary Phone: _____	
Primary E-mail: _____	

COVERED DEPENDENTS

NAME	DOB	SS#	Gender		Relationship
			M	F	
			M	F	
			M	F	
			M	F	
			M	F	
			M	F	

If you have additional dependents and need more space, please attach a separate page

OTHER COVERAGE

I have other coverage ❑ **Yes** ❑ **No**

If Yes, I am covered by: _____ (name of Insurance, Medicare or Medicaid)

My Other Health Insurance Plan Name: _____

My other Health Insurance Group Number: _____

Effective Date of Coverage: _____ This Coverage Ended on: _____

Also covered under this other plan: ❑ **My Spouse** ❑ **My children** ❑ **My spouse and children**

My spouse is employed with health coverage available: ❑ **Yes** ❑ **No** ❑ **NA**

If Yes, type of coverage provided to my spouse:

❑ **Spouse only** ❑ **Spouse and myself** ❑ **Spouse and Children** ❑ **Family** (myself, spouse, children)

My Spouse's Health Insurance Plan Name: _____

Spouse's Health Insurance Group Number: _____

Effective Date of Coverage: _____ This Coverage Ended on: _____

My Children have other coverage ❑ **Yes** ❑ **No**

If Yes, they are covered by: _____ (name of Insurance or Medicaid)

Effective Date of Coverage: _____ This Coverage Ended on: _____

Children covered under this other plan:_____

Please also complete & sign page 2

Averill Anderson, LLC
316 S. Main Street. West Bend. WI 53095
1.800.388.0964

Medicare Coverage:	
Employee Medicare ID# - Part A:	Employee Medicare ID# - Part B:
Spouse Medicare ID# - Part A:	Spouse Medicare ID# - Part B:
Indicate the name of anyone enrolled in Medicare that is currently disabled: _____	
_____	

ACCEPT / DECLINE / AUTHORIZATION

❑ **ACCEPT**: I confirm that all of the information provided above is accurate. I understand that knowingly providing false and/or misleading information may subject me to disciplinary and/or legal action and may result in loss of insurance coverage. I understand that if my dependent(s) become ineligible for coverage that I must report the change to my employer within five working days. I acknowledge receipt of an HRA Brochure and accept all the terms and conditions contained therein.

❑ **DECLINE:** I have been given the opportunity by my employer to apply for the group insurance coverage and after due consideration, have decided *not to take advantage of this offer*. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special enrollment provision or prove insurable through medical underwriting.

❑ **I give representatives of Averill Anderson LLC authorization to discuss my (and my family's) claim processing (EOB) details with representatives of my employer-sponsored health plan.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received the **Averill Anderson, LLC "NOTICE OF PRIVACY PRACTICES"**, revision date January 1, 2010, located within my **HRA Benefit Brochure**. As required by the Privacy Regulations, the **"NOTICE OF PRIVACY PRACTICES"** has been described to my satisfaction.

As required by the Privacy Regulations, I am aware that Averill Anderson, LLC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Averill Anderson, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

I also understand that all plan documents including master plan document, summary plan description and Summary of Benefits and Coverage are available upon request to my employer.

Employee Signature:	(EMPLOYER USE ONLY)
_____ _____ Signature Date	Signed form Received by:_____ Date: _____
_____ Print Name	The following effort was made to obtain Acknowledgement Receipt: _____

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