



HRA ENROLLMENT & CHANGE FORM

Support/Client Services 415-526-1401
 Fax This Form Securely To 415-454-2928
 Email This Form Securely To enrollment@marinbenefits.com
 Website marinbenefits.com

Employee Information					
Employer Name			SSN #	DOB	
Last Name	First Name		Middle Initial	Gender (M/F)	
Address	City		State	ZIP	
Phone	Alternate Phone		Email		
Dependent Information					
First Name	Last Name	SSN #	DOB	Relationship	Gender (M/F)
Employee Authorization & Signature – Not Needed for Terminations or Changes					
I certify that all information is true and correct to the best of my knowledge and agree to the IRS required conditions for reimbursement.					
Employee Signature		Print Name		Date	

To Be Completed By Employer					
New Enrollment <input type="checkbox"/>		Termination <input type="checkbox"/>		Demographic Change <input type="checkbox"/>	Add/Term Dependents <input type="checkbox"/>
Hire Date		Term Date		Other (List)	
Plan Name				Annual Election	
Authorized Signature		Print Name		Date	