HRA ENROLLMENT & CHANGE FORM

Questions? Contact Client Services 415-526-1401
Fax this form to 415-454-2928
Email this form via secure email service to enrollment@marinbenefits.com

EMPLOYEE INFORMATION				
Employer Name		**SSN #**	**DOB**	
Last Name	**First Name**		**Middle Initial**	
Address				
City		**State**	**ZIP**	
Email		**Phone**	**Alternate Phone**	

DEPENDENT INFORMATION				
Last Name	**First Name**	**SSN #**	**DOB**	**Relationship**

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 ☐	**Rehire** ☐	**Termination** ☐	**Demographic Change** ☐	**Add/Term Dependents** ☐	
Other Change? Please list					
Major Medical Plan or HRA Plan Name					
Effective Date		**Hire Date**		**Term Date**	
Authorized Employer Signature		**Print Name**		**Date**	