EMPLOYEE ENROLLMENT FORM
Health Reimbursement Arrangement (HRA)

Submit this completed form via one of the following methods:	Online Support Request	Fax	Mail
	Sign into your online account at cdaclient.basiconline.com and attach the completed form to a support request	(269) 327-0716	BASIC PO Box 6278 Monona, WI 53716

CLIENT/EMPLOYER INFORMATION

Client/Employer Name:		Client/Employer ID:	
Client/Employer Class: (If applicable)		Division: (If applicable)	
Plan Effective Date:			

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		MI:		Last Name:	
Benefits ID: (12 digit)		Email Address:			
Primary Phone #:		Mobile Phone #:			
Primary Address:	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:	+4	
Date of Birth (DOB):*		Gender:	☐ Female ☐ Male ☐ Other		
Social Security Number:*		Hire Date:			
Benefit Effective Date:		Benefit Plan:			
Name of Insurance Carrier:		Election Amount: $			
First Payroll Date:		Payroll Schedule:			
Coverage Tier: (if applicable)					

All fields are required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

**Social Security and date of birth for employees and their dependents are required for HRA reporting purposes to the Centers for Medicare and Medicaid Services as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Enrollment Forms without this required information will be returned for completion. Not all HRA plans require Social Security Number. Prior to leaving blank, check with your Benefits Advisor.*

DEPENDENT COVERAGE INFORMATION

Are you Married?	☐ Yes ☐ No	Have Dependent Children?	☐ Yes ☐ No

If YES to either question, list your spouse/dependent children below:

LAST NAME	FIRST NAME	RELATIONSHIP TO INDIVIDUAL	DATE OF BIRTH	GENDER	Full Time Student	SOCIAL SECURITY #

Must provide spouse and/or dependent information if they are covered under group health plan and eligible for reimbursement under HRA. In order for any service rendered for your spouse or dependent(s) to be covered under this HRA plan, the spouse or dependent receiving the service must be enrolled in your employer sponsored group health plan on the day the service was rendered. Some HRA plans allow coverage under an employer sponsored group health plan offered by another employer. Not all HRA plans require Social Security Number. Prior to leaving blank, check with your Benefits Advisor.

EMPLOYEE ENROLLMENT FORM
Health Reimbursement Arrangement (HRA)

Medicare Beneficiary?	☐ Yes ☐ No ***>> If Yes***, please enter information below:			
LAST NAME	**FIRST NAME**	**RELATIONSHIP TO INDIVIDUAL**	**Medicare ID**	**Entitlement Reason**
				☐ 65+(A) ☐ ESRD (B) ☐ Disabled (G)
				☐ 65+(A) ☐ ESRD (B) ☐ Disabled (G)
				☐ 65+(A) ☐ ESRD (B) ☐ Disabled (G)

BASIC CARD

You will receive one BASIC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

To request an additional BASIC Card for your spouse or dependent, print their name below (or request via BASIC web portal):

1	**Spouse or Dependent Name (First, MI, Last):** (No fee)	
2	**Dependent Name (First, MI, Last):** (Additional fee may apply)	
3	**Dependent Name (First, MI, Last):** (Additional fee may apply)	

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming expenses are covered under the group health plan sponsored by my employer, or another employer if allowed under my plan. I understand that any amounts remaining in my account(s) not used for qualified expenses will be forfeited in accordance with current plan provisions and tax laws.

Signature: _____ Date: _____

For assistance: call toll-free 800-372-3539
Have your form, employer name, and your 12 digit Benefits ID# ready.
Full resources are available on our web page: www.basiconline.com/CDA