GREATER AMSTERDAM SCHOOL DISTRICT
HEALTH REIMBURSEMENT ARRANGEMENT
ENROLLMENT/CHANGE/TERMINATION FORM

1. Name: ________________________ Soc. Sec. # _______ - _____ - ______ Date of Birth __________

Address:____
(Street) (City) (State) (Zip)

Marital Status: __________ Gender: ____ Date of Hire: ________ Termination Date: _________

2. Action to Be Taken:
❑Enroll in HRA Plan ❑Waive HRA Participation ❑Change in Covered Dependents

3. I select the following coverage option:
❑Employee Only ❑Employee & Spouse ❑Employee & Child(ren) ❑Employee & Family

4. List eligible Family members:

Relationship	Name	Gender	Soc. Sec. #	Date of Birth
Self				
Spouse				
Dependent				
Dependent				

Authorization and Agreement: I have read the information describing the Health Reimbursement Arrangement Summary Plan Description, and agree to abide by the terms of the Plan Document. I recognize I must submit signed documents and a Reimbursement Request Form to the Plan's Administrator for the reimbursement of qualified expenses, as determined by the Plan Administrator. I recognize that any expenses I submit for reimbursement must not be covered by any other sources such as insurance.

Employee's Signature: ___________________________________ Date: ________

For District Use Only		
Received by: ___________________	Date: ________	Effective Date:___________