HEALTH REIMBURSEMENT ACCOUNT ENROLLMENT FORM

Employer	Group Number	Effective Date

Employee's First Name	M.I.	Last Name	Date of Birth	Sex (M/F)

Employee Street Address	City, State, Zip Code	Phone Number

Hire Date	Social Security Number	Number of Children

Marital Status: Single ☐ Married ☐ Divorced ☐

Coverage Elected: Single ☐ w/Spouse ☐ w/Children ☐ Family ☐

Complete the following section for any dependents that you are electing coverage for:

Spouses Name	Date of Birth	M/F	Social Security Number
		Female	

Dependent Name (Please list)	Date of Birth	M/F	Social Security Number
		Female	
		Female	
		Female	
		Female	
		Female	

Signature of Employee **Date**

If you and/or any dependent are NOT enrolling, please complete this waiver section.

After careful consideration I have chosen:

_____ ☐ Not to enroll myself and my dependent in the plan

_____ ☐ Not to enroll my spouse in the plan

_____ ☐ Not to enroll my children in the plan

Waiver of Coverage:

Signature of Employee **Date**

Rocky Mountain Administrators

P.O. Box 788

Worland, WY 82401

Phone: (307)347-2606

Fax: (307)347-2646

NAMES YOU KNOW, EXPERIENCE YOU TRUST