

# HEALTH REIMBURSEMENT ARRANGEMENT (HRA)



A PacificSource Company

Phone (541) 485-7488 ♦ (800) 422-7038  
www.manleyplan.com

- Enrollment
- Change

Please return this completed form to your benefits office.

## EMPLOYEE INFORMATION

Employer Name:			
Employee Name:	SSN*:	Date of Birth:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Work Phone:		
E-mail Address:	Manley ID: (if known)		

## DEPENDENT INFORMATION

Dependent information is only required for enrollment in certain plans. Please see your plan administrator to determine whether or not this information is needed for your plan. Only list those dependents you are adding or removing.

Dependent	Last Name	First Name	Middle Initial	Social Security Number*	Date of Birth
Spouse					
Child					
Child					
Child					
Child					
Child					

\* Per Internal Revenue Service (IRS) requirements, Social Security numbers are needed for participants and dependents age 44 and older. For details about this regulation, visit the Centers for Medicare and Medicaid Services (CMS) Web site at [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep).

I hereby certify the above information to be correct and true to the best of my knowledge and that the children or dependents for whom I will be claiming dependent expenses either reside with me in a parent-child relationship or are legally dependent on me for their support.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date

**Employee:** Please return the original to your employer and retain a copy for your records.  
**Employer:** Please forward a copy to Manley Services, unless you will submit a spreadsheet electronically.

**EMPLOYER HR USE ONLY:**

Employee's Effective Date of Coverage/Change: _____	Total HRA Contribution: \$ _____
Division/Class: _____	Qualifying Event: _____

Issue new Benny Card and waive the fee? Y \_\_\_ N \_\_\_