Allegiance℠ by Cigna Healthcare

HRA ENROLLMENT FORM

Please print clearly

EMPLOYER:	DIVISION:		
SSN:	☐ OPEN ENROLLMENT ☐ NEW HIRE ☐ CHANGE* EFFECTIVE DATE (mm/dd/yy):		
NAME:	BIRTH DATE (mm/dd/yyyy):	DATE OF HIRE (mm/dd/yyyy):	
MAILING ADDRESS:	PHONE:	☐ Married ☐ Single	☐ M ☐ F
CITY: STATE: ZIP:	EMAIL:		

I understand that the above named employer will provide the following benefits within the parameters of the health reimbursement arrangement plan document and summary plan description.

HEALTH REIMBURSEMENT ACCOUNT

HRA AMOUNT: $_____ per: ☐ W ☐ BW ☐ SM ☐ M ☐ YEAR (please check one)

ANNUAL AMOUNT ELECTED: $_____

♦ PAY PERIODS - 52 = WEEKLY 26 = BI-WEEKLY (every 2 weeks) 24 = SEMI-MONTHLY 12 = MONTHLY

DEPENDENTS (Use additional paper, if necessary)

	FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER (required by law if over age 1)	BIRTH DATE	SEX M or F
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						

CERTIFICATION *I certify that these are my benefit elections and that:*

1. I understand that coverage applies only to expenses incurred during my period of active participation in the HRA.
2. My HRA election is for expenses for myself, my spouse, and my qualified dependents.
3. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.

Both an employee signature and company authorization are required for enrollment to be completed.

Signed: _____ Date: _____

Company Authorization: _____ Date: _____

*If this is an election change, please indicate the qualifying event:

_____ HR initials _____

2024

For Allegiance use only

Group Number: _____ Date Completed: _____ Entered By (initials): _____

2806 S. Garfield St. P.O. Box4346 | Missoula, MT 59806| Telephone: 877.424.3570 | Fax: 877.424.3539 |www.askallegiance.com