VEBA HRA Enrollment

Submit this completed form to your Human Resources, Personnel, or Benefits Administration Department.

EMPLOYER NAME PLAN YEAR (MM/DD/YYYY – MM/DD/YYYY)

1. EMPLOYEE/PARTICIPANT INFORMATION

LAST NAME FIRST NAME MI Participant Social Security No. (SSN) or Secondary

MAILING ADDRESS ☐ Check here if new address CITY STATE ZIP

DATE OF BIRTH E-MAIL ADDRESS (home or personal recommended) ☐ Check here if new email address AREA CODE/PHONE NUMBER

☐ MALE ☐ FEMALE

☐ MARRIED ☐ UNMARRIED

2. SPOUSE/DEPENDENT INFORMATION

NAME	SSN	Date of Birth	Relationship	Full-time Student? Y/N

3. PARTICIPANT SIGNATURE

X

Participant Signature *Date*