



Employee Benefits Corporation

Enrollment Form

Fax to: 608 831 4790
Mail to: Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347
Phone support: 800 346 2126 | 608 831 8445
E-mail support: participantervices@ebcflex.com

■ Submit completed form to your Employer.

General Information

Organization Name [] Division [] Social Security or Identification Number []

Account Holder Information

Last Name [] Suffix [] First Name [] MI []
Gender M F Date of Birth (mm-dd-yyyy) [] Date of Hire (mm-dd-yyyy) []
Mailing Address [] Apt. No. [] City [] State [] Zip Code []
Home Phone (000-000-0000) [] E-mail Address (we do not share your e-mail address) []

Plan Dates

Employee's Effective Date (mm-dd-yyyy) [] Plan Name (If multiple plan options are available) []

Employment Status

Are you separated from employment? Yes No

Medicare Entitlement

Are you entitled to Medicare? Yes No
If "Yes," please check reason: Aged ESRD Disabled Medicare HICN (if entitled to Medicare) []

Coverage Type

Single Limited Family Family

Family Information

Important: New dependents are not automatically covered under the EBC HRA. Contact HR immediately if you need to add new dependents to your EBC HRA.

Name(s) of Eligible Dependents

Complete this section only if you are applying for Family Coverage and/or Dependent Coverage. List all persons included in coverage; use additional forms if needed.

Eligible Dependent: Last Name [] Suffix [] First Name [] MI [] Social Security or Identification Number []
Relationship to account holder: Spouse Child Domestic Partner Other: [] Date of Birth (mm-dd-yyyy) [] Gender M F
If Medicare Entitled, check reason: Aged ESRD Disabled Medicare HICN (if entitled to Medicare) []

Eligible Dependent: Last Name [] Suffix [] First Name [] MI [] Social Security or Identification Number []
Relationship to account holder: Spouse Child Domestic Partner Other: [] Date of Birth (mm-dd-yyyy) [] Gender M F
If Medicare Entitled, check reason: Aged ESRD Disabled Medicare HICN (if entitled to Medicare) []

Additional information and Authorization - Next page

Family Information (cont.)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Eligible Dependent: Last Name	Suffix	First Name	MI	Social Security or Identification Number
Relationship to account holder:	<input type="radio"/> Spouse	<input type="radio"/> Child	<input type="radio"/> Domestic Partner	<input type="text"/>
	<input type="radio"/> Other:	<input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="radio"/> M <input type="radio"/> F
If Medicare Entitled, check reason:	<input type="radio"/> Aged	<input type="radio"/> ESRD	<input type="radio"/> Disabled	<input type="text"/>
				Medicare HICN (if entitled to Medicare)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Eligible Dependent: Last Name	Suffix	First Name	MI	Social Security or Identification Number
Relationship to account holder:	<input type="radio"/> Spouse	<input type="radio"/> Child	<input type="radio"/> Domestic Partner	<input type="text"/>
	<input type="radio"/> Other:	<input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="radio"/> M <input type="radio"/> F
If Medicare Entitled, check reason:	<input type="radio"/> Aged	<input type="radio"/> ESRD	<input type="radio"/> Disabled	<input type="text"/>
				Medicare HICN (if entitled to Medicare)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Eligible Dependent: Last Name	Suffix	First Name	MI	Social Security or Identification Number
Relationship to account holder:	<input type="radio"/> Spouse	<input type="radio"/> Child	<input type="radio"/> Domestic Partner	<input type="text"/>
	<input type="radio"/> Other:	<input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="radio"/> M <input type="radio"/> F
If Medicare Entitled, check reason:	<input type="radio"/> Aged	<input type="radio"/> ESRD	<input type="radio"/> Disabled	<input type="text"/>
				Medicare HICN (if entitled to Medicare)

Direct Deposit (optional; if you have not done so, complete banking information below to participate – authorization is in effect from year to year)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Financial Institution	City	State	Zip Code
<input type="radio"/> Checking	<input type="radio"/> Savings	<input type="text"/>	<input type="text"/>
	Account Number		Routing Number (exactly 9-digits)

Authorization

Complete the application and sign below. The EBC HRASM will be effective as of the Original HRA Effective Date at the top of the page. All information must be completed accurately and truthfully. The collection of Social Security Numbers (SSN) and Medicare Health Insurance Claim Numbers (HICN) are required by a mandatory reporting law Section 111 of Public Law 110-173 for use by the Secretary of the Department of Health and Human Services for the purposes of coordination of benefits. An official Governmental Alert document can be found at www.cms.hhs.gov/MandatoryInsRep. I have received and read all of the materials explaining the EBC HRA Plan. I understand that I am required to provide this information to participate in this benefit. I understand that as a participant in the plan I must notify my employer of changes in my family members, if applicable. This enrollment form is not an employment agreement.

If Direct Deposit is elected for reimbursement, I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjusting entries) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it.

<input type="text"/>	<input type="text"/>
Signature	Date (mm-dd-yyyy)
<input type="text"/>	
Print Name	