NIAGARA-WHEATFIELD CENTRAL SCHOOL DISTRICT

Teachers' Health Reimbursement Account 105(h)

2009-2010 ENROLLMENT FORM

EMPLOYEE INFORMATION (Please Print)

Employee Name:			Employee Social Security Number:	
Mailing Address:				
City:	State:	Zip:	Home Telephone:	Work Telephone:

Birth Date (Month / Day / Year)	Gender:	Marital Status:	Effective Date: Month/Day/Year	Employer Signature:
	☐ Male ☐ Female	☐ Single ☐ Married	____ / ____ / ____	

DEPENDENTS (Please Print)

Name	Relationship	Birth Date	Social Security #
	spouse		

❑ **I elect to have my HRA check for paper claims directly deposited into either my checking or savings account. (Attach a Direct Deposit Authorization Form).**

EMPLOYER CONTRIBUTION

Health Reimbursement	Amount Contributed
Single: $100 2-Person: $200 Family: $300	$_____

Employee Signature: _____ **Date:** _____

Health Economics Group, Inc.
(585) 241-9500 or (800) 666-6690 Ext. 504
www.heginc.com