Educators Benefit Consultants, LLC
Third Party Administrator

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Health Reimbursement Arrangement
Employee Enrollment Form

PARTICIPANT INFORMATION		
Name:		*Social Security Number:*
Home Street Address:		Phone:
City, State, Zip:		Date of Birth:
Date of Hire:	Date of Retirement/Separation:	Medicare Status: ☐ Eligible ☐ Enrolled
Employer:		Union Employee: ☐ Yes ☐ No
E-mail Address:		Marital Status: ☐ Single ☐ Married

SPOUSAL INFORMATION	
Name:	*Social Security Number:*
Home Street Address:	
City, State, Zip:	Date of Birth:

DEPENDENT INFORMATION		
Name:	Birthdate:	Social Security Number:
Name:	Birthdate:	Social Security Number:
Name:	Birthdate:	Social Security Number:
Name:	Birthdate:	Social Security Number:
Name:	Birthdate:	Social Security Number:

Signature:	Date: