

## Murphy & Associates HRA Participation Form

Murphy & Associates offers you access to their Health Reimbursement Arrangement (HRA) plan administered by Zane Benefits.

Completion of this form indicates your desire to participate in the HRA plan. Please complete the HRA Election form (page 2) and review the Plan Documents (available on the Zane website or upon request).

Benefit Class (select one):

- ☐ Full-Time Employee (\$200/month)
- ☐ Full-Time Employee and Spouse (\$400/month)
- ☐ Full-Time Employee and Child(ren) (\$400/month)
- ☐ Full-Time Employee and Family (\$600/month)
  
- ☐ Part-Time Employee (\$100/month)
- ☐ Part-Time Employee and Spouse (\$200/month)
- ☐ Part-Time Employee and Child(ren) (\$200/month)
- ☐ Part-Time Employee and Family (\$300/month)

\* Full-Time work is based upon 20 hours/week or more.

Employee Name: \_\_\_\_\_

Employee Birth Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dependent Name

Relationship

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Benefits Office Use Only*

Received by Benefits on: \_\_\_\_\_

Benefits Office Staff Member's Signature: \_\_\_\_\_

Hire Date: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Submitted to Zane: \_\_\_\_\_

Entered in M&A Explorer: \_\_\_\_\_

## HRA Election Form

I have read the information describing the Health Reimbursement Arrangement Summary Plan Description and agree to abide by the terms of the Plan Document. I recognize that any expenses I submit for reimbursement must not be covered by any other source such as insurance.

I understand there is a time limit in which to submit qualified expenses following the close of a Plan Year or upon termination of participation, specified in Exhibit 1. I understand that it is my responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of my personal insurance policy.

Signed, \_\_\_\_\_ Date: \_\_\_\_\_

Print Employee's Full Name \_\_\_\_\_