866-451-3399

Health Reimbursement Arrangement (HRA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. This is an internal document used by your employer for data collection purposes. Worksheets returned to WEX Health, Inc. cannot be processed.

*=Required Fields

Step 1: Participant Information

*Employer Name (Do not abbreviate)

*Employee Number

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Home Address

*City

*State

*Zip

*Email Address

Day/Home Telephone

*Date of Birth (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Hours Worked Per Week

*Gender (M/F)

*Marital Status (Married/Single)

Step 2: Account Information

HRA Effective Date (if you're unsure, please verify with your Human Resources contact)

VEBA HRA

If VEBA HRA, please indicate the type of VEBA (For example, Combo VEBA or Full VEBA)

Health Plan Coverage:

Single

EE + spouse

EE + child

EE + children

Family

Medicare Effective Date (if applicable):

Step 3: Dependent(s) on Health Plan

Name	Effective Date	Date of Birth	Relationship	Social Security Number

Step 4: Employee Authorization

I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the Plan Year will be forfeited.

Signature

Date