HRA ENROLLMENT & CHANGE FORM

Support/Client Services 415-526-1401
Fax This Form Securely To 415-454-2928
Email This Form Securely To enrollment@marinbenefits.com
Website marinbenefits.com

Employee Information					
Employer Name				**SSN #**	**DOB**
Last Name		**First Name**		**Middle Initial**	**Gender (M/F)**
Address			**City**	**State**	**ZIP**
Phone		**Alternate Phone**		**Email**	

Dependent Information					
First Name	**Last Name**	**SSN #**	**DOB**	**Relationship**	**Gender (M/F)**

Employee Authorization & Signature – Not Needed for Terminations or Changes		
I certify that all information is true and correct to the best of my knowledge and agree to the IRS required conditions for reimbursement.		
Employee Signature	**Print Name**	**Date**

To Be Completed By Employer						
New Enrollment ☐		**Termination** ☐		**Demographic Change** ☐		**Add/Term Dependents** ☐
Effective Date		**Hire Date**		**Other (List)**		
Plan Name				**Annual Election**		
Authorized Signature		**Print Name**		**Date**		

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