This form is for Non-Debit Card clients only.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ENROLLMENT APPLICATION

Employer: _____

Last, First Name: _____ SSN: _____

Date of Birth: _____ Coverage Effective Date: _____

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email address: _____

Level of Coverage/Election Amount: _____

*(**Example:** Single Coverage / $1000 - or if you only have one level, just enter the HRA election amount. Note: If your company pro-rates, please provide the pro-rated amount you wish to have set up.)*

Dependent Information:

Dependent Name (Last, First): _____

Dependent SSN: _____ Dependent Date of Birth: _____

Gender: ☐ Male ☐ Female Full Time Student: ☐ Yes ☐ No

Relationship (Indicate if they are Spouse or Dependent): _____

Submission to CPN:
Fax: 901.756.8322
Email: katherine@cpnflex.com