



Please send this form along with all applicable receipts to:
1200 River Avenue, Suite 10E, Lakewood, NJ 08701
Fax: 877-747-8564
E-Mail: Claims@flexfacts.com

HRA Activation Form

This form is required to activate your HRA account. When you reach the deductible outlined by your employer please complete this form and provide it along with a copy of your Explanation of Benefits and proof of payment. This form is only required for initial activation. Once activated your HRA funds will be available until they are exhausted or the end of the plan year.

Personal Information

Full Name: _____
Last *First* *M.I.*

Employer: _____

Social Security Number _____

Phone: () _____ E-mail: _____

If your address has changed please list the new address below.

New Address: _____

City, State, Zip _____

If anyone covered under this plan is enrolled in Medicare you must provide their Medicare Claim Number (HICN): _____

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 requires us to report certain HRA enrollment data to the Centers for Medicare & Medicaid Services.

Card Activation

Please activate my HRA Account Benefits MasterCard. I have attached an Explanation of Benefits from my Health Plan indicating the amount of deductible that I have met and proof of payment.

Employee Signature: _____

Date: _____