FORM F
Rev. 10/11/2022

School District ___LNMUUSD___CES___LNSU

Heath Reimbursement Arrangement (HRA)

Participant Enrollment Form

DataPath Administrative Services

Last Name _____ First Name _____ Middle Initial ____

Social Security Number _____ Date of Birth _____ Benefit Start Date 01/01/23

Address _____ City _____ State _____ Zip _____

Home or Cell Phone _____ Work Phone _____ Email _____

Professional/Licensed Staff (Primarily teachers and administration – principals/superintendents)

Health Plan	Single HRA	TP/PC/Fam HRA	Please write in tier level next to correct benefit
Platinum	$1,900	$4,000	
Gold	$1,900	$4,000	
Gold CDHP	$1,900	$4,000	
Silver CDHP	$1,900	$4,000	

Non-Licensed Staff (Non-licensed exempt and hourly)

Health Plan	Single HRA	TP/PC/Fam HRA	Please write in tier level next to correct benefit
Platinum	$2,200	$4,400	
Gold	$2,200	$4,400	
Gold CDHP	$2,200	$4,400	
Silver CDHP	$2,200	$4,400	

Tier level refers to:
S - single
2P - 2 person (adults)
PC - parent/ child(ren)
F - Family

***Please note a card will be ordered for the participant only; if additional cards are needed, please fill out the second page.**

Payment Information

Reimbursement will be made via Electronic Funds Transfer (direct deposit) into your checking or savings account.

Banking information Bank Name _____

Routing number _____ Account number _____

I hereby certify information provided herein to be correct and true and choose to participate.

Signature_____ Date_____

continued from page 1

Medicare Secondary Payor (MSP) Reporting Information (continued from reverse)

** **IMPORTANT: If your spouse or any of your dependents are covered by the health insurance plan listed on the reverse side please complete the form below for each person (besides yourself) who is covered by the plan.**

Dependent #1

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #2

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #3

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #4

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

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If you have more than four dependents covered by this health insurance plan, please provide the above information about each person on a separate sheet of paper and attach to this form.

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