Health Reimbursement Arrangement (HRA) Enrollment Form

Baptist General Convention of Oklahoma
3800 N May Ave
Oklahoma City, OK 73112
Phone: 405-942-3800
Fax: 405-516-4968

Date:

◯ **New** ◯ **Revised**

Employer:

◯ **BVC** ◯ **BGCO**

Employee Name:	
Address:	
State/Province:	
Zip/Postal Code:	
SS Number:	
Best Contact #:	

Who is Enrolling?

◯ Employee Only

◯ Family Member(s) Only

◯ Employee and Family Members

Other Family Members to Enroll

Name (1):		**Name (2):**	
Address:		**Address:**	
State/Province:		**State:**	
Zip/Postal Code:		**Zip/Postal Code:**	
SS Number:		**SS Number:**	
Best Contact #:		**Best Contact #:**	
Relationship:		**Relationship:**	

I request to participate in the HRA for the reimbursement of certain prescribed contraceptive medications, procedures, or devices on behalf of myself or the above named family members on my employer's group medical plan. I understand that only certain specified medications, procedures, or devices are covered by the HRA. I agree to abide by the terms of the HRA. I also agree that if I or a family member exceed the annual limit, my employer is authorized to reduce my salary by the amount for which have exceeded the annual limit of $900 per enrolled individual, or for funds that I have not used in accordance with the rules of the HRA.

_____ _____

Signature Date

Special Notes/Needs: