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HRA ENROLLMENT INFORMATION

Effective/
 Change Date: ___/___/___

- New Enrollment
 Rehire or Reinstatement
 Add/Drop Dependents

- Drop Coverage
 Name Change
 Address Change

EMPLOYEE INFORMATION				
Employer Name: NFTA		Location:		Group Number: J58
Class:		Name (Last, First, Middle):		Date of Birth: Mo / Day / Year
Address: Street		City	State	Zip
Social Security Number:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Full-time employment date:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Name of Spouse:	Spouse Date of Birth:	Date of Marriage:
				Number of eligible children:

COVERAGE INFORMATION				
Coverage Elections (Must be completed)				
	Medical			
	Yes	No		
Employee	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse*	<input type="checkbox"/>	<input type="checkbox"/>		
Child(ren)*	<input type="checkbox"/>	<input type="checkbox"/>		
Family*	<input type="checkbox"/>	<input type="checkbox"/>		
*If Yes, Please complete dependent section below				
List all dependents to be covered including spouse, if applicable:				
Full Name	Relationship	Gender	Date of Birth:	Social Security Number:
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	___-___-___
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	___-___-___
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	___-___-___
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	___-___-___
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	___-___-___

I hereby apply for coverage to which I am entitled or to which I may become entitled under the terms of the employee benefit plan issued to my employer and/or sponsored by my employer. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage.

 Employee Signature _____
 Date