866-451-3399

Health Reimbursement Arrangement (HRA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. **This is an internal document used by your employer for data collection purposes. Worksheets returned to WEX Health, Inc. cannot be processed.**

Group Information

Group Name:

WEX Group Name:

Location Name (if applicable)

Participant Information

*Participant Name (First, MI, Last)

*Social Security Number

*Date of Birth (mm/dd/yyyy)

*Participant Mailing Address

*City

*State

*Zip

Email Address

Primary Telephone

Account Information

HRA

Effective Date (to be provided by group contact)

Health Plan Coverage:

☐ Single ☐ EE + spouse ☐ EE + child ☐ EE + children ☐ Family

☐ Yes. Medicare Effective Date:

Dependent(s) on Health Plan

Name	Effective Date	Date of Birth	Relationship

Employee Signature

I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the Plan Year will be forfeited.

Signature

Date