

# HR Concepts, LLC

"Your Third Party Administrator of Choice"

## Direct Reimbursement Dental Benefit Plan Enrollment Form

Company Name: \_\_\_\_\_

### Part I. Employee (Subscriber) Information:

First Name: _____	Last Name: _____	SS#: ____-__-__
Street Address: _____	City: _____	St: ____ Zip: _____
Phone Number: _____	Date of Birth: _____	Coverage Start Date: _____

### Part II. Spouse and Dependent Children Information:

(Please provide the name of your spouse and dependent children that are to be covered on this Direct Reimbursement Benefit Plan.)

Last Name	First Name	Relationship to Employee	Date of Birth
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____

### Part III. Signature:

**I understand that I cannot change my election during the plan year unless I have a qualifying event. If I do not utilize all of the monies set aside into this account, then I will forfeit this amount. My election will automatically rollover each plan year if I fail to make a new election.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Accepted By Employer: \_\_\_\_\_ Date: \_\_\_\_\_



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