

GettHealth MERP Enrollment Form

Group Number: _____

MEDICAL EXPENSE REIMBURSEMENT PLAN ENROLLMENT INFORMATION

EMPLOYER NAME _____

Effective Date (As of): _____

SOCIAL SECURITY # _____

LAST NAME _____

FIRST NAME _____

MI _____

GENDER: MALE FEMALE

DATE OF BIRTH: ____ / ____ / ____

DATE OF HIRE: ____ / ____ / ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE #: (____) _____

MARITAL STATUS: Single Married Divorced Separated Widow

EMAIL: _____

COVERAGE TIER*: SINGLE 2-PARTY FAMILY

DEPENDENT INFORMATION**:

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

****If you check 2-Party or Family coverage tier, complete the dependent information area.**

*Definition(s): Single (participant has individual coverage under employer's medical plan)

2-Party (participant has husband/wife or parent & 1 child coverage under employer's medical plan)

Family (participant has parent & 2+ children or family coverage under employer's medical plan)

Authorization for Use or Disclosure of Protected Health Information for MERP Administration

I authorize the use/disclosure of health information from the MERP financial account as it pertains to / about me as described below.

1. Person(s) or class of persons authorized to use/disclose the information:

Gettysburg Health Administrators, Inc., my employer and my Human Resource personnel.

2. Person(s) or class of persons authorized to receive the information:

Gettysburg Health Administrators, Inc., my employer and my Human Resource personnel.

3. Description of information that may be used/disclosed:

Financial Information as it pertains to the Medical Expense Reimbursement Plan, specifically, date of service, and provider/facility name (similar to the information received on a credit card bill)

4. The information will be used/disclosed for the following purposes:

Tracking of financial information for my employer's Health Reimbursement Arrangement and/or Flexible Spending Account

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

6. I understand that I may revoke this authorization in writing at any time

This authorization expires upon the MERP plan termination with Gettysburg Health Administrators, Inc. acting as administrator.

Signature of Participant

_____/_____/_____
Date