WageWorks
www.wageworks.com

HRA DEPENDENT INFORMATION

*For employers offering an Integrated HRA**

FILING OPTIONS:

- RECOMMENDED (FASTER & MOST SECURE): Log in to your account and enter this information when you submit your claim online (available 1/1/2017) or on the Profile > HRA Dependents page (available 1/19/2017)
- **Fax:** 844-528-8588

WHY DO I NEED TO COMPLETE THIS FORM?

- Use this form ONLY IF (1) you have not already provided the Social Security Number and date of birth for each dependent whose claims you want considered for payment from an Integrated HRA*, AND (2) you do not intend to enter your claims online (via the website or the WageWorks® EZ Receipts app).
  - You only need to provide this information once per dependent.
  - This information can be provided when you enter a claim online (via the website or the EZ Receipts mobile app).
  - Online is the most secure way to provide this sensitive dependent information.
- IMPORTANT: This information must be received before your dependents' claims are processed in order for their claims to be considered for payment from an Integrated HRA.

ACCOUNT HOLDER INFORMATION

Last Name _____ First Name _____

Employer Name _____

ID Code* _____ Zip Code _____

* ID Code is the last 4 digits of your Social Security Number, your Employee ID number or other reference number assigned by your employer. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

DEPENDENT #1

First Name: _____ Last Name: _____

Relationship to Account Holder (select one):
- ☐ Spouse
- ☐ Qualifying Child
- ☐ Qualifying Relative
- ☐ Other:_____

Full Social Security Number: ___-___-____
- ☐ Dependent SSN not yet received

Date of Birth: MM DD YYYY

DEPENDENT #2

First Name: _____ Last Name: _____

Relationship to Account Holder (select one):
- ☐ Spouse
- ☐ Qualifying Child
- ☐ Qualifying Relative
- ☐ Other:_____

Full Social Security Number: ___-___-____
- ☐ Dependent SSN not yet received

Date of Birth: MM DD YYYY

DEPENDENT #3

First Name: _____ Last Name: _____

Relationship to Account Holder (select one):
- ☐ Spouse
- ☐ Qualifying Child
- ☐ Qualifying Relative
- ☐ Other:_____

Full Social Security Number: ___-___-____
- ☐ Dependent SSN not yet received

Date of Birth: MM DD YYYY

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. If the expense(s) claimed is covered under my Employer's Health Reimbursement Arrangement, I certify that the patient for each claim being submitted is covered under an Affordable Care Act-compliant employer-sponsored group medical plan (their own, mine, or my spouse's). I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter username and password or click on Employee Registration).

*An Integrated Health Reimbursement Account (HRA) is an employer-funded medical reimbursement plan that is linked with an Affordable Care Act (ACA)-compliant employer-sponsored group health plan. Your participation in the group health plan is typically a condition of your coverage under the HRA.