

Please fill out the information below for HRA reimbursement. This application is only for individuals and families that are not signed up for AblePay Health.

In order to accurately process your direct reimbursement you are required to provide complete demographic information for you and any dependents. Please fax, email or mail directly your Explanation of Benefits (EOB) with this attached cover sheet for direct employee reimbursement. AblePay will pay the employee directly with a check mailed to the address listed on this form.

## INDIVIDUAL INFORMATION

Employer Name \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)

Gender \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

## DEPENDENT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)