



HEALTH REIMBURSEMENT ARRANGEMENT ACCOUNT GTM APPLICATION FORM - fax back to 518 836 2555

Effective Date (required):

GTM representative:

7 Halfmoon Executive Park Drive, Clifton Park, NY 12065

Tel: 1.888.432.7972 Fax: 518.836.2555 Info@GTM.com

www.GTM.com

EMPLOYER INFORMATION *(Please print clearly):*

Employer Name:

Employer ID number (if known):

Address: (Street)

(City)

(State)

(Zip Code)

E-mail Address:

Telephone Number:

Effective Date of Plan (when you want the plan to start):

EMPLOYEE INFORMATION *Note: please complete this form separately for additional employees (Please print clearly):*

Social Security Number:

Employee Name: (Last)

(First)

(MI)

E-mail Address:

Hire Date:

or already hired

Birth Date:

Address: (Street)

(City)

(State)

(Zip Code)

HRA ACCOUNT *(Please enter account allocation elections):*

HRA account (MED) – I would like to contribute the amount of \$_____ per _____
(Total annual amount \$_____)

Note: the plan year begins on January 1 and ends on December 31.

I would like to set up an HRA account administered by GTM Employment Benefits, LLC., an affiliate of GTM Payroll Services Inc. I understand there is a \$85 set-up fee and an ongoing \$10 monthly maintenance fee for the HRA account, charged by GTM.

Signature: _____

Date: _____