Direct Reimbursement
Enrollment Form

Administrative Office
Direct Reimbursement, Adm., Services, Ltd.
P.O. Box 292455
Kettering, OH 45429
Tel: 937/428-1046
Fax: 937/428-4831
Email: admin@DirectReimbursement.com

Select Applicable Benefit:

- ☐ Dental
- ☐ Vision
- ☐ HRA
- ☐ FLEX

Employer: ____

I. Policy Subscriber

SSN: ________ - ________- _______________

First Name: ____

MI: __________

Last Name: ____

Date of Birth: _______ / _______ / __________________

Sex:

- ☐ Male
- ☐ Female

Address 1: ____

Address 2: ____

City: ____

State: ____________________

Zip: ____________________

Telephone: (________) - ________ - _________________

Email: ____

Authorized Contact (s) Who Can Discuss benefit information for all covered person(s):

1. ____

2. ____

3. ____

Dependent to be covered: ____

Date of Birth: ______ / ______ / _________________

Relationship: ____

Dependent to be covered: ____

Date of Birth: ______ / ______ / ________________

Relationship: ____

Dependent to be covered: ____

Date of Birth: ______ / ______ / ________________

Relationship: ____

Dependent to be covered: ____

Date of Birth: ______ / ______ / ________________

Relationship: ____

*If more dependents are needed, please list below:

II.

Payment: The cost per person will be determined by your employer and provided to you prior to enrollment.

III.

I hereby apply for the contributory coverage that I have elected above. I am aware that: I am signing up for coverage until the next enrollment period, except in the case of a change in existing benefit status or new enrollment due to new employment. I understand that this coverage will only go into effect if the employer has approved this enrollment. By my signing below, I authorize the required payroll deduction or premium invoicing (if applicable) and represent that all information shown on this form is correct. I understand my benefits may be terminated if applicable payment for benefits is not received.

Participant Signature: ____

Date: ______ / ______ / ________________

Effective Date of Coverage Determined by Employer