PORAC RETIREE MEDICAL TRUST
Administered by Vimly Benefit Solutions, Inc.
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PORAC RETIREE MEDICAL TRUST

Enrollment Form

Check One: ☐ First Enrollment ☐ Dependent Change ☐ Address Change ☐ Name Change

PERSONAL INFORMATION: ***Please Print Clearly***

Beneficiary Name:	Last	First	MI	Social Security Number: - -
Address:				
City:		State:	Zip:	Effective Date:
Phone:	Personal Email:			
Gender: ☐M ☐F	Date of Birth:	Marital Status:	Date of Marriage:	

FAMILY MEMBER INFORMATION: (only list IRS eligible dependents such as spouse and/or children)

Full Name	Birthdate	Relationship to Employee	Gender	SSN	
1).			☐ M ☐ F	- -	☐ Add ☐ Delete
2).			☐M ☐F	- -	☐ Add ☐ Delete
3).			☐M ☐F	- -	☐ Add ☐ Delete
4).			☐M ☐F	- -	☐ Add ☐ Delete
5).			☐M ☐F	- -	☐ Add ☐ Delete
6).			☐M ☐F	- -	☐ Add ☐ Delete

***If you have additional dependents, you may list them on the back of this application.**

Pursuant to the confirmation of my member association, my employer will deduct and remit contributions as specified in the associations collective bargaining agreement on my behalf to the PORAC Medical Expense Reimbursement Plan.

Beneficiary Signature: ___________________________________ Date: ________________________

Internal Use Only:

Employer Name: *Employer Billing Number*

Date Received: ______________________ *Date Processed:* ______________________ *Initials:* ______________________