NORTH SHORE BANK

Enrollment Form

Post-Employment Health Reimbursement Plan (HRA)

414-964-3390 Fax: 262-787-6802 retirement@northshorebank.com

1. Employer Information

Employer Name:____

2. Personal Information (please print)

Name:____SSN: ____________________

Mailing Address: ____

City:_______________________________State:____________Zip: ____________

Date of Birth:__________________Home Phone:__________________Work Phone: __________________

Email Address: ____

Preferred Method of Contact: ☐ Home Phone ☐ Work Phone ☐ Email

3. Spouse/Legal Dependent Information

1. Spouse/Legal Dependent Name:______________________________Date of Birth: ____________________

   Relationship: ____________________________

2. Legal Dependent Name:______________________________Date of Birth: ____________________

   Relationship: ____________________________

3. Legal Dependent Name:______________________________Date of Birth: ____________________

   Relationship: ____________________________

NOTE: for additional dependents, please attach information on a separate page with the Name, Date of Birth, and Relationship of each legal dependent.

4. Signature

Participant or Claimant:

Signature:____Date Signed: ____________________

5. Employer Authorization

Signature:____Date Signed: ____________________

☐ Participant is still employed

☐ Participant has severed employment:

Separation from Service Date: ____________________Amount of Final Payout: ____________________

Funds will be sent via: ☐ Check (mail with Enrollment Form) OR ☐ACH – Date funds will be transferred: ____________

Submission Instructions

Return via mail or fax to:

North Shore Bank
15700 W Bluemound Road Suite 400
Brookfield WI 53005

Fax: 262-787-6802

Questions? **Contact Retirement Services:** 414-964-3390