HRC TOTAL SOLUTIONS
FSA·HRA·HSA·COMMUTER·COBRA·LSA·ICHRA

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) EMPLOYER APPLICATION

I. EMPLOYER INFORMATION

Employer Name:		Tax ID #:	
Business Structure: *		State Organized In:	
Mailing Address:	City:	State:	Zip:
Street Address (if different):	City:	State:	Zip:
Telephone:	Fax:		
Are there any affiliated companies that are also eligible for this benefit? ☐ Yes ☐ No			
* Reminder: Shareholders that are 2% owners of Sub-S corporations, C- corporations' owners not taking a W-2, partners and LLC members are taxed individually. Therefore, a shareholder is not an employee and is not eligible to participate in the HRA. Similarly, the spouse, parents, children, and grandchildren of 2% or more owners can't participate in the HRA.			

II. IMPORTANT CONTACT INFORMATION

Contact Name	Phone #	Email	Type of Contact (check all that apply)	Portal Access
			☐ Primary ☐ Enrollment ☐ Secondary ☐ Billing	☐ Yes ☐ No
			☐ Primary ☐ Enrollment ☐ Secondary ☐ Billing	☐ Yes ☐ No
			☐ Primary ☐ Enrollment ☐ Secondary ☐ Billing	☐ Yes ☐ No
			☐ Primary ☐ Enrollment ☐ Secondary ☐ Billing	☐ Yes ☐ No

Broker Agency:			Phone #:
Broker Contact Name	Phone #	Email	Type of Contact (check all that apply)
			☐ Primary ☐ Account Manager ☐ Secondary ☐ Producer
			☐ Primary ☐ Account Manager ☐ Secondary ☐ Producer

III. PLAN ELIGIBILITY

Please enter the requirements for an employee to be eligible for this plan below, as well as how many employees are employed and eligible.

Hours worked per week:	Length of employment:
Total # of employees:	Total # eligible:
Will you require your reporting to be listed by division? ☐ Yes ☐ No *If **yes**, list the name for each division:*	

IV. GENERAL ADMINISTRATION QUESTIONS

HRAs are COBRA eligible accounts per federal COBRA rules. Who handles the COBRA administration when an employee terminates? _____

HRC TOTAL SOLUTIONS
FSA·HRA·HSA·COMMUTER·COBRA·LSA·ICHRA

V. PLAN DESIGN

Please complete the below section fully to ensure accuracy of plan setup.

1. Medical Insurance Renewal Month:	**2.** Deductible Resets: ☐ Calendar Year ☐ Plan Year
3. Original Effective Date of HRA Plan:	**4.** Plan Year:
5. Will this be a short plan year? ☐ Yes ☐ No *If **yes**, indicate next plan year start and end date:*	
6. What is the annual deductible on the health plan?	**7.** What is the annual EMPLOYER funding of the HRA?
Single: $	Single: $
2 Person: $	2 Person: $
Family: $	Family: $

8. HRA Design Options: Please complete all answers within the option selected below.

☐ Option A

HRA applies to:
- Deductible Only
- 2nd Part of Deductible

Select Auto-Pay Recipient
☐ Employee (recommended)
☐ Provider

Does your medical plan have an embedded* deductible?
☐ Yes
☐ No

Do you want the HRA to also be embedded*?
☐ Yes
☐ No

☐ Option B

HRA applies to:
- Deductible Only
- 1st Part of Deductible

Select Auto-Pay Recipient
☐ Employee (recommended)
☐ Provider

Does your medical plan have an embedded* deductible?
☐ Yes
☐ No

Do you want the HRA to also be embedded*?
☐ Yes
☐ No

☐ Option C

HRA applies to:

Medical	Rx
☐ Deductible	☐Deductible
☐ Copay	☐Copay
☐ Coinsurance	☐Coinsurance
☐ Other	

HRA Pays:
☐ First
☐ Last
☐ Percent of each claim _____%
☐ Other, please complete section 9

Select Auto-Pay Recipient
☐ Employee (recommended)
☐ Provider

Is there a per-member maximum reimbursement amount? _____

Does your medical plan have an embedded* deductible?
☐ Yes
☐ No

Do you want the HRA to also be embedded*?
☐ Yes
☐ No

*An embedded deductible is when a single member of a 2 person or family plan is treated individually for benefits. Each individual would receive the individual maximum on the reimbursement amount as well as the deductible responsibility. There is usually a family maximum that once together the family meets this requirement, any additional individual member will be considered satisfied. Depending on plan design this could limit benefits received or deductible responsibility. In order to have an HRA embedded the pairing medical plan must have an embedded deductible.

HRC TOTAL SOLUTIONS

FSA·HRA·HSA·COMMUTER·COBRA·LSA·ICHRA

9. Please describe in detail how you would like the HRA benefit to pay out. _____ _____ _____
10. Will employer allow carryover of unused funds? ☐ Yes ☐ No *If **yes**, how much? $*
11. Will there be VISA cards for this plan? ☐ Yes ☐ No *If **yes**, what amount of the employer's funds will be available on the VISA Card, if any?* $
12. If your HRA has a debit card; do you want to allow True Substantiation* for substantiation of debit card purchases? ☐ Yes ☐ No *True Substantiation allows HRCTS to Harvest Explanation of Benefits (EOBs) directly from your medical insurance carrier's portal on behalf of each employee to substantiate their debit card purchases.*
13. Are prescriptions subject to the deductible? ☐ Yes ☐ No
14. Will your insurance carrier transmit claim data to HRCTS directly? ☐ Yes ☐ No *If **yes**, who is the carrier?*_____ *If **yes**, make sure owners and anyone not eligible to participate are in a separate excluded group # not coded for the feed.*
15. Do you want to allow True Substantiation* for claims processing? ☐ Yes ☐ No *If **yes**, who is the carrier?*_____ True Substantiation allows HRCTS to Harvest Explanation of Benefits (EOBS) directly from your medical insurance carrier's portal on behalf of each employees to process the claims in the HRA.
16. Do you use an EDI file feed for eligibility? _____ If yes, who is your vendor: _____
Please note on both True Substantiation options that we need to verify your insurance carrier is participating. Additional fees do apply.

VI. FEES AND SIGNATURES

Please review this application carefully, then read and sign that you agree to the below fees.

Setup Fee: $	Annual Renewal Fee: $	
PEPM Fee: $	Monthly Minimum Billing: $	
Combined Account Fees: $		
There will be a funding deposit required for this account administration. The amount is determined after initial enrollment and is equivalent to 7% of the full exposure or $2,000, whichever is greater.		
Comments:		
Authorized Signer's Name (print)	Title	Date
Signature:		