HRC TOTAL SOLUTIONS

Health Reimbursement Arrangement Employer Application (HRA)

Part I. Employer Information

Employer Name:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Street Address (if different):_____ City:_____ State:_____ Zip:_____

Telephone:_____ Fax:_____ Tax ID#:_____

Primary Point of Contact:_____ Phone Ext:_____ Email:_____

Secondary Point of Contact:_____ Phone Ext:_____ Email:_____

Billing Point of Contact:_____ Phone Ext:_____ Email:_____

PHI access is allowed by the following people: (check all that apply)

☐ HR Manager ☐ HR and payroll staff performing HR Functions ☐ Benefits Manager

☐ Plan Administrator

Part II. Plan Design **Medical Renewal Month:**_____ **Deductible runs:** ○ Calendar Year ○ Plan Year

Original Effective Date of HRA Plan:_____ Plan Year:_____ - _____

Short Plan Year: ○ Yes ○ No **(If yes, indicate next plan year)** _____ - _____

What is the annual deductible on the HDHP: Single $_____ 2 Person $_____ Family $_____

What is the annual Employer Funding of HRA: Single $_____ 2 Person $_____ Family $_____

Will Employer allow for carryover of unused funds: ○ Yes ○ No **(if yes, how much)** $_____

When does Employee pay for their portion of the deductible? ○ Before Employer ○ After Employer

Other (please explain): _____

_____

Will there be VISA cards for this plan? ○ Yes ○ No

If yes, what amount of the employer's funding will be available on the VISA card if any: $_____

Will the HRA Track Per member for the family plan? ◉ Yes ○ No

Are prescriptions subject to the deductible? ○ Yes ○ No

Will Employer allow other expenses to be put through the HRA, besides deductible expenses?

○ Yes ○ No If yes, what expenses? _____

Insurance carrier claim feed ○ Yes ○ No If yes, Carrier:_____

Pay the Provider: ○ Yes ○ No

(For internal use only) CE : ○ **Yes** ○ **No** **Rules Plan** ○ **Yes** ○ **No** **Plan is:** ○ **ST** ○ **GR** **AE:**_____

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Part lll. General Administration Questions

HRA's are COBRA Eligible Accounts.

Who handles the COBRA administration when an employee terminates:_____

Part lV. Eligibility

Hours:_____ Length of Service:_____

How Many Employees are Eligible:_____ Total number of Employees:_____

Divisions of Employees: ○ Yes ○ No **If yes, list divisions that need to be set up for reports:**

_____

Part V. Tax filing Information

Business Structure (Ex: S Corp, C Corp, LLC:) _____ State Organized in:_____

Is this a controlled group: ○ Yes ○ No **(If yes, fill in below)**

(Controlled group means the majority owner of company also owns another company as majority owner)

Employer Name:_____ Number of Employees:_____

Address:_____ City:_____ State:_____ Zip:_____

Tax ID#:_____ Business Structure:_____ State Organized in:_____

Part Vl. Signatures and Fees

Broker:_____

Setup/Installation fee: $_____ Account Fee: $_____ Minimum Billing/Month: $_____

Annual Renewal Fee: $_____ Account Fee: $_____ Minimum Billing/Month: $_____

Comments: _____

Authorized Signature of ER: _____ Title:_____ Date:_____

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