



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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

II. IMPORTANT CONTACT INFORMATION

Contact Name	Phone #	Email	Type of Contact (check all that apply)	
			<input type="checkbox"/> Primary	<input type="checkbox"/> Enrollment
			<input type="checkbox"/> Secondary	<input type="checkbox"/> Billing
			<input type="checkbox"/> Primary	<input type="checkbox"/> Enrollment
			<input type="checkbox"/> Secondary	<input type="checkbox"/> Billing
			<input type="checkbox"/> Primary	<input type="checkbox"/> Enrollment
			<input type="checkbox"/> Secondary	<input type="checkbox"/> Billing

Broker Agency:			Phone #:
Broker Contact Name	Phone #	Email	Type of Contact (check all that apply)
			<input type="checkbox"/> Primary <input type="checkbox"/> Account Manager
			<input type="checkbox"/> Secondary <input type="checkbox"/> Producer
			<input type="checkbox"/> Primary <input type="checkbox"/> Account Manager
			<input type="checkbox"/> Secondary <input type="checkbox"/> Producer

III. PLAN ELIGIBILITY

Please enter the requirements in order 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, list the name for each division:</i>	

IV. GENERAL ADMINISTRATION QUESTIONS

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

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

1. Medical Insurance Renewal Month:	2. Deductible Resets: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year	
3. Original Effective Date of HRA Plan:	4. Plan Year:	
5. Will this be a short plan year? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, indicate next plan year start and end date:</i>		
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.		
<input type="checkbox"/> Option A <i>HRA applies to:</i> <ul style="list-style-type: none"> • Deductible Only • 2nd Part of Deductible Select Auto-Pay Recipient <input type="checkbox"/> Employee (recommended) <input type="checkbox"/> Provider Does your medical plan have an embedded* deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want the HRA to also be embedded*? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Option B <i>HRA applies to:</i> <ul style="list-style-type: none"> • Deductible Only • 1st Part of Deductible Select Auto-Pay Recipient <input type="checkbox"/> Employee (recommended) <input type="checkbox"/> Provider Does your medical plan have an embedded* deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want the HRA to also be embedded*? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Option C <i>HRA applies to:</i> Medical Rx <input type="checkbox"/> Deductible <input type="checkbox"/> Deductible <input type="checkbox"/> Copay <input type="checkbox"/> Copay <input type="checkbox"/> Coinsurance <input type="checkbox"/> Coinsurance <input type="checkbox"/> Other HRA Pays: <input type="checkbox"/> First <input type="checkbox"/> Last <input type="checkbox"/> Percent of each claim _____% <input type="checkbox"/> Other, please complete section 9 Select Auto-Pay Recipient <input type="checkbox"/> Employee (recommended) <input type="checkbox"/> Provider Is there a per-member maximum reimbursement amount? _____ Does your medical plan have an embedded* deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want the HRA to also be embedded*? <input type="checkbox"/> Yes <input type="checkbox"/> 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.



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. Are prescriptions subject to the deductible? Yes No

13. Will your insurance carrier transmit claim data to HRCTS directly? Yes No
If yes, who is the carrier?

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.		
Fee Comments:		
Authorized Signer's Name (print)	Title	Date
Signature:		