

DOCUMENTS EMPLOYER APPLICATION

I. EMPLOYER INFORMATION

Employer Name:			
Mailing Address:	City:	State:	Zip:
Street Address (if different):	City:	State:	Zip:
Telephone:	Fax:		
Total # of employees:	Total # eligible:		
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"/> Secondary <input type="checkbox"/> Billing <input type="checkbox"/> Doc Portal Access
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Billing <input type="checkbox"/> Doc Portal Access
Broker Agency:			Phone #:
Broker Contact Name	Phone #	Email	Type of Contact (check all that apply)
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Account Manager <input type="checkbox"/> Producer
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Account Manager <input type="checkbox"/> Producer

III. TYPE OF DOCUMENT REQUESTED

<input type="checkbox"/> ERISA WRAP	<input type="checkbox"/> EBHRA
<input type="checkbox"/> Premium Offset Plan (POP)	<input type="checkbox"/> QSEHRA
<input type="checkbox"/> FSA/DCA	<input type="checkbox"/> Retiree HRA
<input type="checkbox"/> Limited Purpose FSA	<input type="checkbox"/> Wellness HRA
<input type="checkbox"/> S132/Commuter	<input type="checkbox"/> ICHRA
<input type="checkbox"/> HRA	<input type="checkbox"/> Limited Purpose HRA (dental/vision)

IV. GENERAL PLAN INFORMATION

A questionnaire will be provided to you to complete with all the information needed for us to create your plan documents. Once returned to HRCTS your documents will be prepared for you. Documents will not be provided until payment is received.

V. FEE AND SIGNATURE

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

Annual Fee: \$		
Fee Comments:		
Authorized Signer's Name (print)	Title	Date
Signature:		