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HRA Data Gathering Form & Processing Guidelines

Name of Organization: _____
(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Benefit Coordinator: _____ Title: _____

E-mail Address: _____ Federal Employer ID No: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address: _____ Zip: _____

- Organization Type:
- Corporation.
 - Professional Corporation
 - Partnership
 - Government Agency
 - Other _____
 - Sub-chapter "S" Corporation
 - Professional Association
 - Sole Proprietorship
 - LLC Limited Liability Company

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Health Reimbursement Arrangement.

PLAN ELECTIONS

- Linked HRA (to health insurance plan) Unlinked HRA (stand alone dental, vision, etc.)

HEALTH PLAN INFORMATION

Name of Health Insurance Carrier _____

Contract # _____

Health Plan Year Effective Date: ____/____/____ Health Plan-Year-End Date: ____/____/____

Carrier Deductible Effective Date: ____/____/____ Carrier Deductible End Date: ____/____/____

In-Network Deductible Maximum *Out-of-Network* Deductible Maximum

Single \$ _____ Single \$ _____

Two Party \$ _____ Two Party \$ _____

Family \$ _____ Family \$ _____

HRA PLAN DESIGN

Plan No.: _____ ex.501,502

Plan Name: Section 105 HRA Plan

First Year Effective Date: ____/____/____

First Year Plan-Year-End Date: ____/____/____

Plan Year Begin Date: ____/____/____

Plan-Year-End Date: ____/____/____

ELIGIBILITY REQUIREMENTS

The following class of employees is eligible to participate:

- All
- Salaried Employees Only
- Hourly Employees Only
- Other _____

The following employees are excluded from participation:

- Same as employer’s group health plan
- No exclusions.
- Part-time employees normally expected to work less than _____ hours a week.
- Employees under the age of _____.
- Union employees (*unless the bargaining agreement provides for coverage*).
 - Non-resident aliens.
 - Other: _____

The service period employees must complete before being eligible to participate is as follows:

For the initial plan year, any one employed on the Plan Effective Date and for subsequent Plan Years:

- Same as employer’s group health plan.
- As of date of hire.
- Number of days after date of hire: _____
- Number of months after date of hire: _____

For all plan years:

- Same as employer’s group health plan.
- As of date of hire.
- Number of days after date of hire: _____
- Number of months after date of hire: _____

Employees must be in service or on the job as one of the eligibility requirements.

Once the employees are eligible, they can begin participating in the plan:

- Same as employer’s group health plan
- Date employee becomes eligible.
- First day of pay period following the date employee becomes eligible.
- First day of month following the date employee becomes eligible.
- First day of quarter following the date employee becomes eligible.
- First day of Plan Year following the date employee becomes eligible.

BENEFITS

Check the benefits to be offered under this Plan:

Unlinked Benefits

- _____
- _____
- _____
- _____
- _____

Linked Benefits

- Health Insurance
- Dental Insurance
- Vision Insurance
- Other: _____
- Other: _____

REIMBURSEMENTS

Claims Closing Date: 90 days after the plan year

Minimum Check Amount: \$1.00

Claim Closing Date for Terminated Employees: 90 days after end-of-coverage

Claims to be Paid first: FSA Medical HRA

REIMBURSEMENT METHODS

- Direct Mail (to participant's home)
- ACH (only offered if reimbursed from Human Resource Administrators, Inc. bank account)
- mySource Card debit card (for use with stand alone first dollar reimbursement HRA Plans)

DEPOSIT & REPLENISHMENT

Initial Deposit Amount is \$_____

Replenishment will occur at 50% of the initial deposit

The initial deposit and replenishment will be provided via:

- Check to HRA, Inc.
- EFT Bank Draft from account listed below initiated by HRA, Inc. upon prior notification.
- Reimbursement checks will be issued directly from the employer's account listed below.

*Required

*Name of Bank: _____

*Bank Address: _____

*Bank City: _____ Bank State: _____ Bank Zip Code: _____

*Name on Account: _____

*Account Number: _____

*Bank Routing No. (MICR) (Ex: 123456789): _____

*Bank Routing No. (Bank Info) (Ex: 111-42/348): _____

*Person(s) Signing Check: _____

REPORTING

- Weekly Check Register sent via ___ fax ___ e-mail.
- Monthly Reports sent via ___ e-mail ___ direct mail.

ADMINISTRATIVE FEES

- \$_____ installation fee
- \$_____ per participant per month
- \$_____ annual renewal fee
- \$_____ monthly per participant per card fee
- \$_____ second card or re-issued mySource Card fee

These documents are being printed at the direction of the person named below, who is either a professional authorized before the Internal Revenue Service or acting under the direction of such professional. It is understood that Human Resource Administrators, Inc. is not engaged in the practice of law. Any unanswered questions may result in errors in the Plan produced by using the information from this worksheet. I understand that in the preparing the document requested, Human Resource Administrators, Inc. is utilizing information shown on this Data Gathering Form to produce documents using a format which has been designed by Human Resource Administrators, Inc. and Human Resource Administrators, Inc. has made NO REPRESENTATION OR WARRANTY OF ANY KIND, expressed or implied, including no warranties of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, nor is any opinion, expressed or implied, rendered by its attorney's as to the legal effect, sufficiency or tax qualification of any document utilizing Human Resource Administrators, Inc. format.

Signature (Required)

Date