HRA
Human Resource Administrators, Inc.

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HRA Data Gathering Form & Processing Guidelines

****Please provide the carrier's Schedule of Benefits for the underlying policy along with this form.****

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: ___________

Phone Number: _______________________ Fax Number: _____________________

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

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

Will other affiliations or subsidiaries be using this plan? ❑Yes ❑ No **If <u>Yes</u>**, then please provide the additional information on the last page.

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: _________________________ Plan

Is the first HRA plan year a short year?

If *YES*, then please complete the short year dates:
First Short Year Effective Date: ___/___/___ First Year Short Plan-Year-End Date: ___/___/___

When is the first full plan year and when does the HRA Plan Renew♦ (**Replenish**)?
Plan Renewal♦ (**Replenish**) Date: ____/____/____ Plan-Year-End Date: ____/____/____

If *NO*, then please complete the following information:

When is the effective of the first full plan year and when does the HRA Plan Renew♦ **(Replenish)**? The renewal month and day will be the same as the Effective Date month and day.

Effective Date & Renewal♦ (**Replenish**) Date: ____/____/____ Plan-Year-End Date: ____/____/____

♦ Renewal is when participants' will again receive the full allotted HRA benefit amount. If the HRA Plan dates match the health plan instead of the deductible, plan design changes may occur on the date of the health plan renewal. Please inform Human Resource Administrators, Inc. of any such changes.

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 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

REIMBURSEMENT CAP

Maximum Linked HRA Benefits:	Single Coverage	$_______
	Two Party Coverage	$_______
	Family Coverage	$_______
Maximum Unlinked HRA Benefits:	$________________	
Maximum Cap per Benefit: (Current Year Benefit + Rollover)	Single Coverage	$_______
	Two Party Coverage	$_______
	Family Coverage	$_______

Portion to be Rolled Over per Benefit/Overall: $ or %____________

For mid-year hires, are benefits going to be pro-rated based on plan entry? ❑ Yes ❑ No

COVERED EXPENSES UNDER THE SELECTED BENEFIT:

Subject to Section 213 Expenses*

Linked*

❑ In-network deductible ❑ Out-of-network deductible ❑ Co-insurance
❑ Other: ______________________________

Unlinked*

❑ All Dental expenses except: ______________________________
❑ All Vision expenses except: ______________________________
❑ All 213(d) expenses
❑ Other: ______________________________

HOW EXPENSES ARE TO BE PAID:

Example $50.00 copay 100% wellness benefit

❑ First Dollar Reimbursement
❑ Second half the deductible, aggregated per member
❑ Employee pays a portion, HRA pays, then employee is responsible for the last portion

Single Coverage:	Employee Pays $______	HRA Pays $________	Employee Pays $________
Two Party Coverage:	Employee Pays $______	HRA Pays $________	Employee Pays $________
Family Coverage:	Employee Pays $______	HRA Pays $________	Employee Pays $________

❑ 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

Does the health insurance coverage cease on the date of termination or the end-of-month in which they terminate?
❑ termination date ❑ end-of-month

Claims to be Paid first: ❑ FSA Medical ❑ HRA

REIMBURSEMENT METHODS (Check all that apply)

❑ 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:
HRA initial deposit is $_____✱ + mySourceCard deposit for Benefit Bank $______ TOTAL = $______
✱ A review of the cash-on-hand is done monthly. An invoice will be issued when the level of funding is 50% of the initial HRA 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

❑ Monthly Reports sent via ____e-mail ____ direct mail.

ADMINISTRATIVE FEES

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

How will admin. fees be paid? ❑ EFT on the 10th of the month from acct. listed above ❑ Check

ADDITIONAL AFFILIATIONS OR SUBSIDIARIES USING THE PLAN

Number One:

Company Name: ____

Mailing Address: ____

City: _______________________________________ State: ____________ Zip: ___________

Street Address: ____ Zip: ___________

Phone Number: ________________________ Federal Employer ID No: __________________

Number Two:

Company Name: ____

Mailing Address: ____

City: _______________________________________ State: ____________ Zip: ___________

Street Address: ____ Zip: ___________

Phone Number: ________________________ Federal Employer ID No: __________________

These documents are being printed at the direction of the person named below. 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 form 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