HR Concepts, LLC

"Your Third Party Administrator of Choice"

Health Reimbursement Arrangement Employer Application (HRA)

Part l. 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 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 ll. Plan Design   **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: **Broker Pays: Setup Renewal Admin**

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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