

Health Reimbursement Arrangement Application

Date: _____

General Information:

Employer Name: _____ Telephone: _____
Legal Name: _____ Fax: _____
Street Address 1: _____ Tax ID #: _____
Street Address 2: _____ Tax Year End: _____
City, State, Zip: _____

Contact Name: _____ Title: _____
E-Mail: _____

Insurance Agent: _____

Type of Entity: C-Corporation Limited Liability Company taxed as a:
 S-Corporation Partnership
 Professional Service Corporation Sole Proprietorship
 Sole Proprietorship C-Corporation
 Partnership S-Corporation

Member of a: Controlled Group (provide entity names, Tax ID #s, plan types sponsored)
 Affiliated Service Group (provide same as above)
 Not Applicable

Payroll Schedule: Weekly Bi-Weekly Semi- Monthly Monthly
Payroll Processing Date: _____
Pay Period End Date: _____
Total # of Employees: _____

Plan Information:

Effective Date: New Plan _____
 Restatement _____ Plan #: _____
(please provide copy of current plan, SPD and 5500, if applicable)

Plan Year: Calendar Year (January 1 - December 31)
 Short Plan Year [_____ to _____]
 Fiscal Year [_____ to _____]

Open Enrollment: November December Other: _____

Eligibility to Participate:

Excluded No exclusions
Employees: Part-time employees expected to work less than _____ hours per week
 Employees not participating in Employer-provided health insurance
 Employees not eligible to participate in Employer-provided health insurance
 Employees subject to collective bargaining agreement.
 Other: _____

For purposes of determining continued eligibility under the plan, will retired employees be considered eligible employees: Yes No

Eligibility Criteria: Same as group health insurance plans
 Immediate
 _____ days following date of hire
 Other: _____

Entry Date: First day of month following satisfaction of eligibility criteria
 Date on which eligibility criteria are satisfied
 First day of following Plan Year
 Other: _____

Coverage Extended to: Participant Only
 Participant's Tax Dependents

COBRA Continuation of Benefits: Not Applicable [< 20 employees in prior year]
 Must continue coverage under COBRA to continue
 Need not continue coverage under COBRA to continue

Plan Design:

Type: Comprehensive - reimburses all health care expenses not covered by Insurance
 Bridge - reimburses only those health care expenses subject to a deductible
 Benefits shall be paid *after* the employee portion of the deductible has been met
 Benefits shall be paid *before* the employee portion of the deductible begins
 Coinsurance expenses shall be included in this benefit
 Limited - reimburses those expenses not covered by insurance, as indicated below:
 Co-payments
 Deductibles
 Dental expenses
 Vision expenses
 Prescription and Over-the-Counter drugs and medicines
 Other: _____
 Premium Only - reimburses premium expenses for individually-owned insurance
 Health insurance premiums
 Dental insurance premiums
 Disability insurance premiums
 Long-term care insurance premiums
 Other: _____

Employer Contribution: \$ _____ for employee-only coverage during plan year
(excludes carryover) \$ _____ for employee and spouse coverage during plan year
\$ _____ for employee and children coverage during plan year
\$ _____ for family coverage during plan year

Accrual Rate: Once per Plan Year [1st day of Plan Year]
 Monthly [1st of each month]
 Quarterly [1st of each quarter]
 Pro rata [coordinated with payroll dates]

Account Balance Carryover: Not permitted
 Permitted
 Employee-only coverage maximum: \$ _____
 Employee and spouse coverage maximum: \$ _____
 Employee and children coverage maximum: \$ _____
 Family coverage maximum: \$ _____

Reimbursements:

Frequency: Weekly (Friday)
 Monday, Wednesday, Friday
 Daily [increased monthly administration fee applies]

Method: Check or Direct Deposit
 Check Only
 Direct Deposit Only

Debit Card: Make available [increased annual administration fee applies]
 Do not make available

Funding: From Employer Account
Routing Number: _____
Account #: _____
Start with Check #: _____
 From ASAP Flex Plans, Inc. Account [some advance funding required]

Following Termination: Only expenses incurred prior to termination
 Expenses incurred through Plan Year end

Grace Period: 30 days following Period of Coverage
 60 days following Period of Coverage
 90 days following Period of Coverage

Order of Payment: Not Applicable
 Eligible health care expenses must be paid first from this plan
 Eligible health care expenses must be paid first from FBP

Miscellaneous:

Participant Reports: Not Applicable
 Provide annually - by end of month following Plan Year end
 Provide semi-annually - by end of month following Plan Year end and

Insurance Co-Pays (if applicable): _____

Prescription Co-Pays (if applicable): _____

Date: _____

Employer Name

By: _____

Printed: _____

Title: _____