beneflexinc.com

## EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT INFORMATION

As an employer, Health Reimbursement Arrangements (HRAs) give you a variety of options for the administration of your plan however, the following rules must be incorporated:

HRAs must be funded solely by the employer and may not be linked or directly funded by an employee payroll deduction.

HRAs may not be limited to specific classes of employees on a discriminatory basis (such as only for highly compensated employees) as defined in IRS Code section 105.

COBRA applies to HRAs. Those eligible for COBRA may elect to continue HRA coverage under COBRA..

HRAs may not allow cash outs to terminating employees.

An HRA may not reimburse an expense incurred before the HRA came into existence or before the employee was enrolled in the HRA.

The HRA may only be used to reimburse employees, former employees (including retiree's) and/or their tax dependents or medical care expenses as defined under Code Section 213 (which includes both health insurance premium/contributions and reimbursement of otherwise unreimbursed medical expenses).

The completion of this entire form is necessary to prepare your Plan Document. When you have completed both pages of this form, please return to Beneflex Inc. either by fax or by mail.

## EMPLOYER INFORMATION FOR PLAN DOCUMENT - PLEASE PRINT

Company Name: ______________________ EIN Number: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________ Phone #: ______________________

Contact Person Name: ______________________ Phone #: ______________________ Ext: __________

Start Date of Plan: ______________________ An employee of the company regularly performing services at least __________ hours per week shall become eligible for the plan on the first day of the month coincidental with or next following the date the employee completes __________ days of consecutive employment.

## EMPLOYER HRA BANK ACCOUNT INFORMATION - PLEASE PRINT

BENEFLEX will initiate a draft from the account you designate below for reimbursement of qualified employee claims. You will be notified of qualified reimbursements amounts via email or fax prior to initiation of any draft.

Name of Bank: ______________________ Type of Account: ☐ Checking ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐ (First 9 numbers on bottom left of check)

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I certify that by signing this agreement, I authorize Beneflex Inc., to initiate drafts from the account indicated above for the purpose of reimbursing qualified claims incurred by my employees through their Health Reimbursement Arrangement account.

Name: ______________________ Date: __________

BENEFLEX will draft their fee of $5.00 per plan participant on the 28th of each month. You will be notified of the total fee amount prior to the initiation of this draft. If you would like to use the above account for Beneflex to draft their monthly fees, leave the below information blank and continue on next page.

Name of Bank: ______________________ Type of Account: ☐ Checking ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐ (First 9 numbers on bottom left of check)

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I certify that by signing this agreement, I authorize Beneflex Inc., to initiate drafts from the account indicated above for the purpose of reimbursing qualified claims incurred by my employees through their Health Reimbursement Arrangement account.

Name: ______________________ Date: __________

## EMPLOYER CHOICES FOR HEALTH REIMBURSEMENT ACCOUNT

**1.** Plan or Plans being offered being offered: ☐ HRA ☐ MedFSA ☐ Health Insurance Premium Conversion Plan (POP)
(Salary Reduction for insurance premium cannot exceed premium cost)

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**2.** HRA funded amount will be based on insurance deductible ☐ Yes ☐ No
(Insurance deductibles are different if employee only vs family coverage.)

If YES, what percentage of deductible will be contributed to the HRA______ %

Deductible for Employee Only Coverage $ ____________________

Deductible for Family Coverage $ ____________________

If NO, what amount will be contributed to the HRA $ ____________________

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**3.** The HRA accounts will be funded by the employer:

Monthly ☐ In the amount of $ __________________ Annually ☐ In the amount of $ __________________

Quarterly ☐ In the amount of $ __________________ Semi-Annually ☐ In the amount of $ __________________

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**4.** Employees can rollover an entire unused account balance to the next year: ☐ Yes ☐ No

If NO, dollar amount of rollover allowed $ ___________________ or percentage of balance of rollover allowed __________%

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**5.** Employees are eligible to participant after completing an average of _____________ hours each ☐ week ☐ month

over the last _____________ ☐ weeks ☐ months

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### IF COBRA ELECTED, THEN COBRA RULES MUST GOVERN.

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**6.** If an employee terminates: (No COBRA elected)

☐ Account is closed and no request for reimbursement of expenses incurred after termination date accepted.

☐ Account remains open until remaining balance expended.

☐ Account remains open and $ _____________ contributed each cycle for ________ cycles.

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**7.** If an employee retires:
(No COBRA elected)

☐ Account is closed and no request for reimbursement of expenses incurred after retirement date accepted.

☐ Account remains open until remaining balance expended.

☐ Account remains open and $ ______________contributed each cycle for ________cycles.

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**8.** Should the death of an employee occur:
(No COBRA elected)

☐ Account is closed and no request for reimbursement of expenses incurred after death.

☐ Account remains open until remaining balance expended by a qualifying family member.

☐ Account remains open and $ ______________ contributed each cycle for ________ cycles.

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### OTHER EMPLOYER SPECIAL PLAN OPTIONS (List or attach additional information sheets)

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**Signed:** ______________________________________________ **Dated:** ____________