

Health Reimbursement Arrangement New Client Form

Company Information

Name of Plan Sponsor:

Street:

City, Zip, State:

Contact Name:

Tel: Fax: email:

Plan Sponsor EIN: Fiscal Year End:

Entity type: C Corp S Corp Nonprofit Partnership LLC LLP SoleProp Gov Agency

Plan Data

Plan Name: Plan Number:

Effective Date: Previously-Adopted Plan Date:

Plan Year End (Month Day): Short Plan Year: If Yes enter Date:

Is the Plan subject to ERISA?

Eligibility

Eligibility Requirements:

Excluded Employees Union Leased NRA Part-Time Other:

Service Requirements

Minimum Age: Minimum Service Requirement: Entry Dates:

Permit Eligible Employees to participate in the Plan after Termination?

Eligible Medical Expenses

Coverage under the Plan for Covered Persons is available for the following Eligible Medical Expenses:

All Allowable Expenses Listed Expenses Health Plan Deductibles Health Plan Coinsurance

Exclude coverage for Over-The-Counter-Drugs: Yes No

Modifications to the definition of Eligible Expenses:

Schedule of Expenses outlined on attached Exhibit A

Covered Person

The definition of Covered Person under the Plan shall include the following persons:

Participant Spouse Dependents Persons covered under Company Medical Plan Other

Maximum Health Reimbursement Benefit that will be Credited

- to a Participant's HRA in any Plan Year for one Covered Person:
- to a Participant's HRA in any Plan Year for two Covered Persons:
- to a Participant's HRA in any Plan Year for more than two Covered Persons:

Health Reimbursement Account - Deductible

- deductible in any Plan Year for one Covered Person:
- deductible in any Plan Year for two Covered Persons:
- deductible in any Plan Year for more than two Covered Persons:

Health Reimbursement Account - Procedures

The benefit amount shall be credited to the Participant's HRA at the following times:

Beginning of Plan Year Semi Annually Quarterly Monthly

If a Participant enters the Plan not at the beginning of period, the amounts credited to the HCRA shall be reduced to reflect the time of actual participation in the Plan: Yes No

If a change to the number of covered persons affects the amount credited to the HCRA contributions will be prorated to accommodate the change: Yes No

Does the Plan allow a carryover of the balance in a Participant's HRA to the next Plan Year? Yes No

If Yes - limited to dollar amount: - limited to multiple of maximum annual benefit: Yes No

If "Yes with limitations", enter the maximum dollar amount (or multiple of the maximum annual amount) that may be carried over to the next Plan Year:

Coordination with Other Plans for Expenses that are Reimbursable under both Plans

Cafeteria Plan: None HRA First Cafeteria Plan First

Health Savings Accounts: None Permitted Coverage Post Deductible Coverage

If "None", the limitations shall apply to: All Participants Only Participants in the HDHP

Former Employees

If a former employee is allowed to participate in the Plan after Termination, select what benefits are available:

Plan Year spend-down Other:

Deadline for filing Reimbursement Claims

Number of days after end of Plan Year: Specified Time:

Deadline for claims submission for Terminated Participants: Yes No

Number of days after Termination or the specified date:

Will the Company provide debit, credit, and/or other stored-value cards: Yes No

Designation of Plan Administration

Plan Sponsor Committee appointed by Plan Sponsor Other

Other Plan Provisions

Employee ID used for Plan: SSN Other None

Claims should be submitted to the Plan Sponsor Other:

Is the Plan is subject to COBRA: Yes No

If Yes - Number of Days within which a Participant must notify the Plan

If Yes - Contact person to be listed in the COBRA Notice: Plan Sponsor Other:

Indicate whether the Plan is subject to HIPAA privacy rules: Yes No

Indicate whether the Plan is subject to HIPAA portability rules: Yes No

Indicate whether the Plan is subject to FMLA: Yes No

Coordination with the Company sponsored Health Plan

SPD information about how the HRA coordinates with company sponsored health insurance: Yes No

If Yes - Deductible only Other information only Deductible and other information

Enter the Company health insurance plan deductible:

Exhibit A - Health Reimbursement Account - Schedule of Expenses

OTHER NOTES:

Broker Information:

Plan Fees: