HRA Data Form

** If sponsoring more than one HRA plan, complete a separate form for each.*

Plan Elections

HRA TYPE ☐ **Traditional** ☐ **EBHRA** ☐ **ICHRA** ☐ **QSEHRA**

Section 105 HRA Plan Name ______________________________

Plan Beginning Date ____________________ Plan Ending Date ____________________

Plan Effective Date ____________________ First Year Effective Date ____________________

Contact Information

Company Name ______________________________ Tax ID ____________________

Address ____________________ City ____________________ State _____ Zip ____________

Contact Last Name ____________________ First Name ____________________ Middle Initial __________

Phone (____)______________ Fax (____)______________ E mail ______________________________

Eligibility Requirements

The following class of employees is eligible to participate:

All employees Salaried employees only Hourly employees only

☐ Other (specify) ______________________________

The following employees are excluded from participation **(check all that apply)**

☐ No exclusions

☐ Part-time employees normally expected to work less than _____ hours per week

☐ Employees under the age of ________

☐ Union employees (unless the bargaining agreement provides for coverage)

☐ Employees with Non-Resident Alien immigration status

☐ Other(specify) ______________________________

The Service Period Employees Must Complete Before Being Eligible To Participate (check all that apply)

☐ For the initial Plan Year, anyone employed (in service or on the job) on the Plan Effective Date; then for subsequent Plan Years:

____ As of date of hire _____ days after date of hire _____ months after date of hire

☐ For all Plan Years, anyone employed (in service or on the job):

☐ As of date of hire _____ days after date of hire _____ months after date of hire

Once eligible, when employees can begin participation in the Plan

☐ On date of eligibility

☐ First day of pay period following eligibility date

☐ First day of month following eligibility date

☐ First day of quarter following eligibility date

☐ First day of Plan Year following eligibility date

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Overhead Coverage And Eligible Expenses

☐ Health/Major Medical Plan Carrier Name: ______________________

☐ Deductible ☐ Co-Insurance ☐ Prescriptions ☐ Co-Pays (Office Visits/Prescriptions) ☐ EOB Required

☐ Other (specify) ______________________

☐ Dental/Orthodontic Plan Carrier Name: ______________________

☐ Deductible ☐ Co-Insurance ☐ Co-Pays ☐ EOB Required ☐ Other (specify) ______________________

☐ Vision/Optical Plan Carrier Name: ______________________

☐ Deductible ☐ Co-Insurance ☐ Co-Pays ☐ EOB Required ☐ Other (specify) ______________________

☐ Other (specify) ______________________

☐ Plan is not linked to overhead coverage

Expenses eligible for reimbursement include all Section 213 qualified products and services

☐ Other (specify) ______________________

Reimbursement/Benefit Tier*

*If individual HRA value is $1,000 or more for any participant, please complete the separate MSP Reporting data form

Flat rate (All Tiers) $ __________ per plan year (All)

☐ Flat rate (Different Tiers)

EE Only	
EE & Spouse or plus One	
EE & Child(ren) or plus Two	
EE & Family or Three or More	

☐ Amount varies by coverage status

☐ Employee Only $ __________ per plan year

☐ Employee + Spouse $ __________ per plan year

☐ Employee + Child/ren $ __________ per plan year

☐ Family $ __________ per plan year

☐ Annual Level ☐ Annual Prorated ☐ Prorate for eff date only ☐ Accrual, how often __________ and $: ________

Run Out: _____ /_______ /_______
mm/dd/yy

Run out for terminated employees:_____ /_______ /_______
Date or Days

Plan Design

Insurance (Medical) Deductible ______________ HRA Deductible ______________

Deductible met before benefit pays out: (This is the max amount for Employees)

	Dollar Amount	Percentage
EE Only		
EE & Spouse or plus One		
EE & Child(ren) or plus Two		
EE & Family or Three or More		

Other Information: ______________________________

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Maximum Amount paid out by Employer:

	Dollar Amount Max amount for ER: $
EE Only	
EE & Spouse or plus One	
EE & Children or plus Two	
EE & Family or Three or More	

Other Information: ______________________________

Carryover*

Will there be a carryover? ☐ Yes (specify amount below) ☐ No

Carryover Date* ____________________ Run Out Date for Terminated EEs** __________________

Benefits Term after Termination: ☐ End of Month ☐ Date of Termination ☐ Other

☐ Entire accumulated unused account balance (no cap on amount carried over)***

☐ Accumulated unused account balance, up to $__________ max. amount carried over***

☐ Other*** (specify)______________________________

**The carryover portion of a participant's total HRA account balance pays at 100%*
***Carryover to be done 90 days to allow payout of claims for previous plan year*
****If individual HRA value combined (after carryover) can reach $1,000 or more, complete the MSP Reporting data form*

Benefit Order

☐ HRA pays first, then FSA ☐ FSA pays first, then HRA ☐ Other ______________________________

☐ Not Applicable

Reimbursement Frequency

☐ Daily (claims processed and paid on the business day following the business day on which Beneliance receives claim)

☐ Weekly on __________ (day of week) ☐ Monthly on__________ (day of month)

☐ Per Pay Period (Bi-Weekly or Semi-Monthly) ☐ Other ______________________________

Reimbursement Methods

☐ mySourceCard® or Summit debit card (available only "first-dollar" plan designs)

☐ ACH Deposit plus Direct Checks (checks mailed by Beneliance direct to participants)

☐ ACH Deposit plus Employer Batch Checks (checks mailed by Beneliance. in bulk to Employer for signing and distribution)

☐ ACH Deposit (no checks)

☐ Other (please explain)______________________________

Funding Frequency

☐ Monthly ☐ Beginning

☐ Quarterly ☐ Other ______________________________

Define the method of funding

Employer Signature: ______________________________ **Date:** ______ /________ /_______
mm/dd/yy

DataPath Signature: ______________________________ **Date:** ______ /________ /_______
mm/dd/yy

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