

Health Reimbursement Account Plan Application

For questions please call the numbers listed below. Please mail the completed application to the address listed below
J. Peat & Associates 20 Blake Avenue, Lynbrook, NY 11563-2506 Tel: (516) 599-2120 Fax: (516) 599-3135

1. Legal Name of Company Sponsoring Plan: _____
2. Business Entity Type:
 - C Corp.
 - S Corp.
 - Limited Liability Company
 - Partnership
 - Sole Proprietorship
 - Not-For-Profit
 - Government -Entity or Church
3. Principal Business Activity: _____
4. Federal Employer Identification Number (must be 9 digits): __ _ -- _ _ _ _ _ _ _ _
5. Contact Person: _____ Title: _____
6. Street Address (No PO Boxes): _____
City, State, Zip: _____
7. Phone Number: _____ Fax Number: _____
E-mail Address: _____
8. Effective Date – This HRA plan will be:
() A new plan effective as of (date) _____
9. Plan Year – The first plan year for the HRA will be:
A 12-consecutive-month period beginning (date) _____ and ending (date) _____
A short plan year beginning (date) _____ and ending (date) _____
10. Employer's Principal Office – This HRA plan shall be governed under the laws of the:
State of ___ New York _____ Commonwealth of _____
11. Please **exclude** the following employees from the HRA Plan:
Mark all boxes that apply
 - Employees not eligible under Employers group medical plan
 - Employees not enrolled in the Employers group medical plan
 - Part-time Employees expected to work less than _____ hours per week
 - Commissioned Employees
 - Union Employees
 - Other (type & attach) _____
- 12a. All employees can enter the HRA Plan (Mark only one):
 - Same as Employer's group medical plan
 - _____ days after date of hire
- 12b. If 12a is "Same as Employer's group medical plan" please provide group medical plan's eligibility period:

13. **Benefits.** The Plan shall reimburse Eligible Employees for the cost of Eligible Medical and Dental Expenses (as defined under Internal Revenue Code Section 213 and as further described below). Unused amounts cannot be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution (None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred).

Eligible HealthCare Expenses. The following categories of expenses qualify for reimbursement under the Plan:

- Option A (Bridge): Covers reimbursement of Out-of-Network Deductible only, up to \$2,000-single and \$4,000-family
- Option B (Bridge): Covers reimbursement of Out-of-Network Deductible only, up to \$1,000-single and \$2,000-family
- Option C (Comprehensive): Covers reimbursement of any eligible healthcare expense, up to \$1,000-single and \$2,000-family

14. **Contributions.** Other than for Retiree/COBRA continuees, the employer shall make all contributions for this Plan. The employer shall make contributions to the Plan in the following manner:

- On an annual basis at the beginning of the Plan Year.
- On a quarterly basis at the beginning of each quarter within the Plan Year.
- On a monthly basis at the beginning of each month within the Plan Year.
- On a pro rata basis, coordinating with employee pay dates, within the Plan Year.

15. **Order of Benefit Payments.** If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan:

- Eligible Medical and Dental Expenses must be paid under the Section 125 Plan before this Plan;
- Eligible Medical and Dental Expenses must be paid under the Section 125 Plan after this Plan;
- Applicable health insurance premiums are paid under this Plan before being paid under the Section 125 Plan.

16. Payroll is prepared: _____ In-house _____ Out-sourced (specify payroll company): _____

17. Employer Funding Method:

- By check
- ACH transfer
- Wire transfer

18. Employer Claim Funding Cycle:

- Monthly
- Bi-Monthly

19. Number of pay periods per year: _____

20. Total number of eligible employees: _____ Total number enrolled: _____

21. Grace period during which claims may be submitted after end of plan year 60 days Other _____

22. Grace period during which claims may be submitted after employee termination 60 days Other _____

23. Legal names(s) of affiliated company(ies) that will be covered by this plan: (provide names, tax ID numbers and full addresses) (**Companies with common ownership may have one plan document with one company shown as the plan sponsor and other affiliated companies adopting the same plan. These companies may have different Federal ID numbers, locations and payroll sources. The adopting companies, along with their ID numbers and addresses will be shown in the plan document and Summary Plan Description).

Pricing Information

24. Fee for New Plan Setup, Plan Takeover or Restatement. \$ Included in Monthly Fee

25. Monthly Administrative Bank/Participant Service Fee: \$ Included in Monthly Fee

26. Fee for Annual Plan Compliance: \$ Included in Monthly Fee. This fee is collected one month prior to the beginning of each new plan year.

Plan Administrator Signature*: _____ Date: _____

(*This should be the employer or designee. J. Peat & Associates will provide administrative services but will not be the Plan Administrator.

Name of Broker: _____ Affiliated Company: _____
Address (No PO Boxes): _____
City, State, Zip: _____
Phone: _____ Fax: _____ E-Mail: _____

The referring company or its representative may earn a fee for services performed in connection with the installation of this plan.