Health Reimbursement Arrangement
HRA PLAN SET-UP

COMPANY INFORMATION	Referred by:	Of:	Phone # ☐☐☐-☐☐☐-☐☐☐☐
Employer Legal Name:		Contact Person:	
Address:		Email Address:	
City: State: Zip:		Phone: ☐☐☐-☐☐☐-☐☐☐☐	
EIN: ☐☐-☐☐☐☐☐☐☐		# of Employees on Group Med Ins. ☐☐☐	
List Any Affiliated Companies & % Ownership:			
Plan # ☐502 ☐ 501 *ERISA Plan Number for 5500 (if required)*	☐ Sole Proprietor* ☐ Sub-S* ☐ Partnership* ☐ LLC* * 2% or more Owners may not participate	☐ C-Corporation Owners may participate	

HRA PLAN PROVISIONS

Current HRA Plan? ☐Y ☐N	Plan Effective Date: ☐☐-☐☐-☐☐☐☐	Amended Date: ☐☐-☐☐-☐☐☐☐

PLAN YEAR	**PART TIME**	**ELIGIBILITY FOLLOWING**
Begins: ☐ Jan 01 or ☐_____ Ends: ☐ Dec 31 or ☐_____	☐ Exclude ☐ Include Defined as working ☐☐Hrs/Wk	☐30 Days ☐ 60 Days ☐ 90 Days ☐_____Days Of Employment with the Company

HRA Type: ☐Covers Only Employees participating in Group Medical Insurance -OR- ☐ Covers all Eligible Employees

Covered Expenses: ☐Deductible Only ☐IRS Allowable Medical Expenses (§213) ☐Group Ins Premiums Only ☐See unique specification below

Unique Specifications:

For New Hires: Will the benefit be pro-rated Year one? ☐Yes ☐ No

Claims: Which Pays First? ☐Café Plan ☐HRA Plan

Plan Year Carryover after "run-out ☐No Carryover ☐No Limit ☐Accumulate up to $☐☐☐,☐☐☐☐

Terminated Employees Have: ☐60 days to claim services thru DOT ☐ No time limit ☐ Only Retirees may claim account balance

Employer Subject to COBRA? ☐Yes *Would you like Ben-X, LLC to assist with your COBRA needs? ☐Yes please ☐ No thanks
☐No, we have fewer than 20 employees (counting full time and fractional part time employees)

HRA FUNDING

☐Option 1: Employer will send a Monthly contribution report along with funds to Ben-X. Claims will be paid up to amount on deposit.

☐Option 2: Employer will maintain a claim account balance equal to 10% of projected annual contribution so that claims may be paid upon submission by plan participants. Employer will send contribution report with funding.

☐ Option 3: Ben-X will bill Employer for claims as claims are submitted by Plan Participants. Claim will be processed upon Ben-X receiving claim funding from Employer. Employer will send contribution report with funding.

Amount of Employer Contribution: ☐$ Single ☐$ 2Party ☐$ Family(based on Option Selected above)

Employer Funding Options: ☐ Employer Check ☐ Set up ACH arrangement

☐ A Census of all covered Employees and the amounts they will receive accompanies this form *(Required)*

I understand that in addition to this completed form, I will provide Ben-X, LLC a list of covered Employees and the Amount they will receive on a monthly or annual basis as chosen above. I understand that it is the responsibility of the Employer to notify Ben-X, LLC of any changes to the Employee list either by deletion or addition. I understand that Ben-X, LLC processes claims each business day; however payments can only be made from funds on deposit.

Sign Here _____ Company Representative _____ Title _____ Date

Ben-X, LLC www.MyBenX.com Fax (801) 224-1903 · Phone (801) 229-2369 · Toll Free (888) 433-2369 ·

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