ASURE SOFTWARE

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN
Renewal Check List

EMPLOYER INFORMATION

Employer Legal Name ______________________ Federal Employer ID No. / Tax ID No. ______________________

Primary Contact Name /Title	Phone	Fax	Email
Secondary Contact Name/Title	Phone	Fax	Email
Broker Information	Phone	Fax	Email

Are there any changes being made to the HRA plan for the upcoming plan year? ❑ Yes ❑ No
If yes, please answer the questions listed below that pertains to the changes being made and notify our office if you'd like to make any amendments to your current Plan Document/SPD (additional fee applies).

If no, please return this page along with signature page to Mangrove.

****NOTE:** If the questions listed on this document are not answered, we will use the prior year's renewal documents.

ADMINISTRATION DATA

Full Plan Name: ______________________ **State of Plan's Origin:** ______________________

Original Plan Effective Date: ______________________ **IRS Plan Number:** ______________________

Plan Year Start and End dates: From: ____________ To: ____________
Open Enrollment Start and End dates: From:____________ To: ____________
Total number of employees: ____________ Total number of eligible employees: ____________

Would you like to offer the Benefits Debit Card? ❑ Yes ❑ No
This card can be utilized for HRA eligible expenses at authorized merchants (no additional charge applies for employee card).

PLAN DESIGN

Are all employees eligible for this plan? ❑ Yes ❑ No

If there are exclusions, please indicate:
- ❑ Part-time employees who work less than ________ hours per week
- ❑ Employees with less than ________ months of employment
- ❑ Employees under the age of ________
- ❑ Contract employees
- ❑ Other: ______________________

When does participation commence for a new eligible employee (waiting period)?

❑ None ❑ 1st Month after hire date ❑ 30 Days ❑ 1st Month after 30 days
❑ 60 Days ❑ 1st Month after 60 days ❑ 90 Days ❑ 1st Month after 90 days ❑ Other: ____________________

Are retired employees eligible to participate in this plan? ❑ Yes ❑ No
If "yes", are they eligible to participate continuously under section 125 benefits, or only until the end of the plan year? ________________

If you currently offer a Health FSA Plan and an HRA, claims are to be paid first out of the: ❑ Health FSA ❑ HRA

HRA BENEFITS

❑ Linked HRA (Linked To Underlying Health Plan) ❑ Unlinked HRA

Linked HRA - An HRA that is connected to a major medical health plan, usually a High Deductible Health Coverage (HDHC) policy/ plan. The Employee must be a Participant in the health plan to participate in its associated (linked) HRA.

Unlinked HRA/Stand-Alone HRA - HRA designed to pay for certain eligible medical expenses. Not tied to any major medical health plan.

If this is a Linked HRA, please provide the following information:
Insurance Carrier Name:________________________________ Group Number: ____________________________
Plan Name and Description (i.e. HMO, PPO or POS): ____
Carrier Contact Name: ________________________________ Phone Number: ____________________________
When does the health plan renew? ____________________
Is the deductible plan year or calendar year?______________

Covered expenses under the selected benefit ***(Check all that applies)*****:**

❑ Applies to the deductible credited on underlying insurer EOB – Includes:
 ❑ Medical Expenses ❑ Prescription Expenses
❑ Applies to co-insurance credited on underlying insurer EOB
❑ Applies to in-network benefits
❑ Applies to out-of-network benefits
❑ Applies ONLY to prescriptions
❑ Applies ONLY to office co-pays
❑ Other (please be specific): ______________________________

If the HRA is linked to the Health Plan Deductible, please specify the Health Plan Deductible below:

Individual:	$
Family (2or >):	$

Other Design (please specify):

	$
	$
	$
	$

HRA FUNDING & REIMBURSEMENTS

Employer HRA Maximum Funding Limit (Reimbursement Cap):
Maximum Annual Individual Limit for HRA Benefits: $_______________
Maximum Annual 2 or > Limit for HRA Benefits: $_______________
(Generally, this max is 2 X the single limit)
Comments: ____

HRA Reimbursement Plan Design *(Check all that applies)*:

- ❑ 100% of claim will be paid from the HRA up to maximum limit
- ❑ The First $ _____________ is paid by the ❑ Employer ❑ Employee
- ❑ The Second $ __________________ is paid by the ❑ Employer ❑ Employee
- ❑ The Third $ _____________ is paid by the ❑ Employer ❑ Employee
- ❑ Other:

  The ❑ First ❑ Second ❑ Third
  $ _______________ will be paid by the Employer at ____________%

Comments: ____

When will the HRA funds be available to the employees?

- ❑ Full Annual HRA Funds will be available at the beginning of the plan year or upon eligibility
- ❑ First of each month (employer contribution / 12 months)
- ❑ Customized – List the contribution dates: ____

Do you allow your employees to roll over any unused HRA funds to the subsequent plan year? ❑ Yes ❑ No
If yes, what is the allowed roll over amount or percentage?

- ❑ Full Unused Amount
- ❑ Up to $ _______________
- ❑ ______________%

Do you allow employees to elect a one-time rollover of their unused HRA dollars into a Health Savings Account?

❑ Yes ❑ No

Spend-Down Feature

Spend-Down Feature – 2002 IRS Guidance permits an employer to design an HRA so that terminating employees can use up their HRA account balance until exhausted, no later than the end of the plan year. Employees can spend-down an account balance by getting reimbursed for expenses incurred after employment terminates. Cash-outs are not allowed. Some employers may not want a spend-down feature (unused funds are forfeited). Whether or not an HRA has a spend-down feature, COBRA must be offered.

Do you want to allow a Spend-Down feature for HRA funds upon termination? ❑ Yes ❑ No

If you've answered "No," how much time do you want to allow terminated employees to submit claims which incurred prior to their termination date?

❑ 0 days ❑ 30 days ❑ 60 days ❑ 90 days ❑ Other: _________ days

Run-Out Period

The run-out period permitted under IRS Notice 2005-42 gives active employees an extended amount of time for submitting expenses for that were incurred during the coverage period (HRA plan year).

Do you want to allow a Run-Out Period? ❑ Yes ❑ No

If you've answered "Yes," how much time do you want to allow active employees to submit claims which incurred during the HRA plan year?

❑ 30 days ❑ 60 days ❑ 90 days ❑ Other: ____________ days

When does the HRA participation cease for a terminated employee?

- ❑ Date of termination
- ❑ The last day of the month following date of termination

HRAs & COBRA:

An HRA is a group health plan generally subject to the COBRA continuation coverage requirements. If an individual elects COBRA continuation coverage, an HRA complies with these COBRA requirements by providing for the continuation of the maximum reimbursement amount for an individual at the time of the COBRA qualifying event and by increasing that maximum amount at the same time and by the same increment that it is increased for similarly situated non-COBRA beneficiaries (and by decreasing it for claims reimbursed). Premiums are determined under the existing rules in §4980B. In Rev. Rul. 2002-41, Situation 1, a qualified beneficiary who chooses to elect COBRA continuation coverage may only elect the HRA in conjunction with the major medical plan. However, a qualified beneficiary may choose to elect COBRA continuation coverage for only the major medical plan.

Employer is entitled to bill COBRA participant 1/12 of the HRA maximum benefit listed above (+2% optional surcharge) unless rollover election is selected. With a rollover option an actuary must be retained to determine COBRA premium.

ACH INFORMATION

For debit card funding and manual claim processing, please provide banking information for a business checking account. This is referred to as the Employer Funding Account. Manual claim reimbursements via check and/or direct deposit will be cut from this bank account based on your reimbursement frequency and card transactions will be deducted via ACH daily. Mangrove will issue a summary of card settlement daily, and the funds will deducted the following day. Clients will also receive detail reporting of manual claim payment and card transaction details weekly (or other frequency if desired).

During Implementation, a $1 non refundable ACH debit pre-note will be initiated to verify the account. If you have an ACH block on the bank account, the following ACH filter information should be communicated to your bank to ensure the ACH debits are not blocked.

Submitting Bank: M&I Bank
Routing Number: 075000051
Company ID: 1383261866

Company Name (Account Name): Metavante
Origination ID: 07500005
Tax ID: 38-3261866

EMPLOYER'S BANKING INFORMATION

Name of Bank: ______________________
Bank Routing Number: ______________________

Name on Account: ______________________
Account Number: ______________________

Authorized signature(s) to use for electronic signature on manual claim checks:
(Please sign inside the box with BLACK)

Starting Check Number to use for check reimbursements: __________
(Starting check # 500 will be used if a number is not specified)

CLAIMS

Manual Claims Reimbursement Frequency: ❑ Daily (as claims are processed) ❑ Weekly (Mondays)

Which Reimbursement Options would you like to offer to your employees: ❑ Check ❑ Direct Deposit

Who within your organization would you like to receive our funding reports for Manual Claim Reimbursements and Debit Card Settlement Funding?

Name: ______________________ Email: ______________________
Name: ______________________ Email: ______________________
Name: ______________________ Email: ______________________

❑ **I have reviewed the information provided herein and have verified that it is accurate and complete.** As information changes, it is the responsibility of the employer to communicate the changes in a timely manner to Mangrove.

COMPANY NAME: ______________________

______________________ ______________________
SIGNATURE **DATE**

______________________ ______________________
PRINT NAME **TITLE**