# Employer Application for HRAs and FSAs

HealthEquity
Building Health Savings™

**Please note, handwritten options or deviations from this application will not be accepted.**

## Employer Profile

| Company Name | Tax ID: | |
|---|---|---|
| Street Address 1 | City | |
| Street Address 2 | State | ZIP |

| Phone (area code) | Fax (area code) |
|---|---|

**Employer Entity:** (Check one) ☐ C Corporation ☐ S Corporation ☐ Sole Proprietorship ☐ Limited Liability ☐ Government or Church ☐ Non-profit

An HRA may provide tax-free benefits only to employees, former employees, retirees, and their spouses or covered tax dependents. Because self-employed individuals are not "employees," an HRA may not provide tax-free benefits to self-employed individuals (i.e., sole proprietors, partners, and more-than-2% Subchapter S corporation shareholders).

**Number of Benefit-Eligible Employees:** ___________ **Estimated Number of Enrollees:** HRA _______ FSA _______ Other _______

**Employees Are Eligible:** ☐ Immediately on Hire Date ☐ After ____ Days of Employment

## Employer Contact

| Plan Contact (questions regarding plan) | E-mail | Phone (area code) | Fax (area code) |
|---|---|---|---|
| Funding Contact (questions regarding funding) | E-mail | Phone (area code) | Fax (area code) |
| Billing Contact (questions regarding billing) | E-mail | Phone (area code) | Fax (area code) |

**Who is your health plan provider?**_______________________________________

**Who is your health plan account executive?**______________________ **Phone number:**__________ **Email:**______________

If you use a broker, please provide name, phone number, and email: ______________________________

**What is the health plan's medical deductible?**

Individual: $__________ EE + Child: $__________ EE + Spouse: $__________ EE + Children: $__________ Family: $__________

**Do you have health savings accounts (HSAs)?** ☐ Yes ☐ No **Do you have HSAs with HealthEquity?** ☐ Yes ☐ No

## HRA Plan 1 (Please note, handwritten options or deviations from this application will not be accepted.) Group Number:______________

| Plan Year Start Date | Plan Year End Date | HRA Plan Type<br>☐ Traditional ☐ Incentive ☐ Post Deductible HRA (PDHRA) |
|---|---|---|

If PDHRA, are employees eligible for dental and vision prior to meeting the deductible? ☐ Yes ☐ No

What are your deductible amounts? (2014 IRS minimums are $1,250 for single and $2,500 for family) Single $___________ Family $___________

**Plan Year Run-Out End Date:**______________________________

Run-out is the number of days after the end of the plan year the HRA will continue to pay for expenses incurred during the plan year. Rollover funds are not available until run-out period is complete.

**Plan Year Run-Out Days for Terminated Employees:**

☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ____ days ☐ or by plan year run-out date

**Note:** Run-out is the number of days after the end of the plan year the HRA will continue to pay for expenses incurred during the plan year. Rollover funds are not available until run-out period is complete. HRA will pay expenses for terminated employees that were incurred on or before the termination date, if received within this number of days following termination.

**Eligible Medical Expenses:** ☐ Deductible ☐ Co-pays ☐ Coinsurance ☐ All 213(d) medical **Is RX Allowed?** ☐ Yes ☐ No

**Would you like to turn on autopay?** (Applies to integrated claims. Claims will be automatically paid to the selected payee. Co-pays always auto-pay to member if auto-pay to provider is selected.) ☐ No ☐ Yes

Select payee: ☐ Member ☐ Provider

Would you like members to be able to turn off autopay?** ☐ Yes ☐ No

*A debit card is not allowed on integrated claims when autopay is turned on. **If autopay is not turned on, members will need to manually release claims payments through the portal.

## HRA Plan 1 (Cont.)

**Will a debit card be issued with this HRA plan?** ☐ Yes* ☐ No

*To determine whether plan permits a debit card, please review matrix on page 5.

**If yes, which expenses are reimbursable on the debit card:**

☐ Rx ☐ All 213(d) expenses

**Annual HRA Employer Contribution** ($ amount, not %)

Individual: $________ EE + Child: $________ EE + Spouse: $________ EE + Children: $________ Family: $________

**Is the employer HRA contribution prorated for employees enrolling mid-year?**

☐ No. ☐ Yes. If yes, ☐ Monthly or ☐ Quarterly

**Does HRA have a deductible?** ☐ No. HRA begins to pay on first qualified expense. ☐ Yes. If "yes," see 1 and 2 below.

**1. Is there a per person HRA deductible?** ☐ No. ☐ Yes*. Amount $________

*If "yes," HRA will pay for the covered dependent once deductible is met even if aggregate deductible from #1 above has not been met.

**2. Annual HRA Aggregate Deductibles** (Employee pays this amount prior to HRA paying. All dependents accrue towards this amount.)

Individual: $________ EE + Child: $________ EE + Spouse: $________ EE + Children: $________ Family: $________

**Is there an individual payment cap?**

☐ Yes. Maximum amount HRA pays to any individual family member is: $________ ☐ No.

**Will unused HRA funds roll over from one plan year to the next?**

☐ Yes. Unused funds roll over into the next plan year. Maximum roll over amount $______ up to a maximum accumulation of $______

If yes, are there funds that need to be rolled over from a prior administrator? ☐ Yes ☐ No

☐ No. Unused funds will not roll over into the next plan year.

**Note:** Funds cannot roll over to the following plan year until the run-out period is over.

## HRA Plan 2 (Please note, handwritten options or deviations from this application will not be accepted.) Group Number:__________

| Plan Year Start Date | Plan Year End Date | HRA Plan Type<br>☐ Traditional ☐ Incentive ☐ Post Deductible HRA (PDHRA) |
|---|---|---|

If PDHRA, are employees eligible for dental and vision prior to meeting the deductible? ☐ Yes ☐ No

What are your deductible amounts? (2014 IRS minimums are $1,250 for single and $2,500 for family) Single $________ Family $________

**Plan Year Run-Out End Date:** __________

Run-out is the number of days after the end of the plan year the HRA will continue to pay for expenses incurred during the plan year. Rollover funds are not available until run-out period is complete.

**Plan Year Run-Out Days for Terminated Employees:**

☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ____ days ☐ or by plan year run-out date

**Note:** Run-out is the number of days after the end of the plan year the HRA will continue to pay for expenses incurred during the plan year. Rollover funds are not available until run-out period is complete. HRA will pay expenses for terminated employees that were incurred on or before the termination date, if received within this number of days following termination.

| **Eligible Medical Expenses:** | ☐ Deductible ☐ Co-pays ☐ Coinsurance ☐ All 213(d) medical | **Is RX Allowed?** ☐ Yes ☐ No |
|---|---|---|

**Would you like to turn on autopay?** (Applies to integrated claims. Claims will be automatically paid to the selected payee. Co-pays always auto-pay to member if auto-pay to provider is selected.) ☐ No ☐ Yes

Select payee: ☐ Member ☐ Provider

Would you like members to be able to turn off autopay?** ☐ Yes ☐ No

*A debit card is not allowed on integrated claims when autopay is turned on. **If autopay is not turned on, members will need to manually release claims payments through the portal.

**Will a debit card be issued with this HRA plan?** ☐ Yes* ☐ No

*To determine whether plan permits a debit card, please review matrix on page 5.

**If yes, which expenses are reimbursable on the debit card:**

☐ Rx ☐ All 213(d) expenses

**Annual HRA Employer Contribution** ($ amount, not %)

Individual: $________ EE + Child: $________ EE + Spouse: $________ EE + Children: $________ Family: $________

**Is the employer HRA contribution prorated for employees enrolling mid-year?**

☐ No. ☐ Yes. If yes, ☐ Monthly or ☐ Quarterly

## HRA Plan 2 (Cont.)

**Does HRA have a deductible?** ☐ No. HRA begins to pay on first qualified expense. ☐ Yes. If "yes," see 1 and 2 below.

**1. Is there a per person HRA deductible?** ☐ No. ☐ Yes*. Amount $__________

*If "yes," HRA will pay for the covered dependent once deductible is met even if aggregate deductible from #1 above has not been met.

**2. Annual HRA Aggregate Deductibles** (Employee pays this amount prior to HRA paying. All dependents accrue towards this amount.)

Individual: $__________ EE + Child: $__________ EE + Spouse: $__________ EE + Children: $__________ Family: $__________

**Is there an individual payment cap?**

☐ Yes. Maximum amount HRA pays to any individual family member is: $__________ ☐ No.

**Will unused HRA funds roll over from one plan year to the next?**

☐ Yes. Unused funds roll over into the next plan year. Maximum roll over amount $_________ up to a maximum accumulation of $________.

If yes, are there funds that need to be rolled over from a prior administrator? ☐ Yes ☐ No

☐ No. Unused funds will not roll over into the next plan year.

**Note:** Funds cannot roll over to the following plan year until the run-out period is over.

## FSA Plan 1 (Please note, handwritten options or deviations from this application will not be accepted.) Group Number:__________

| Plan Year Start Date | Plan Year End Date | **Plan Year Run-Out End Date*:**__________<br>*Run-out is the number of days after the end of the plan year the FSA will continue to pay expenses incurred during the plan year. |
|---|---|---|

**Plan Year Run-Out Days for Terminated Employees:** ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ______ days

FSA will pay expenses for terminated employees incurred on or before the termination date if received within this number of days following the termination date. ☐ or by plan year run-out date

**Grace Period Days:** ☐ 0 days ☐ 75 days ☐ Other _______ days (Cannot exceed 75 days.)

The FSA grace period provides an additional time period after the end of the plan year to incur expenses against the FSA.
This time period begins the first day following the end of the plan year.

**Grace Period Days for Terminated Employees:** ☐ 0 days ☐ 75 days ☐ Other _______ days (Cannot exceed 75 days.)

Election Minimum: $__________ Election Maximum: $__________

**FSA Plan Type(s):** ☐ Full Health Care FSA ☐ Limited-Purpose FSA (LPFSA)* If LPFSA, is it also post-deductible?** ☐ Yes ☐ No

*Limited dental, vision, preventative expenses
**If post-deductible, the LPFSA switches to a full health care FSA once the IRS deductible is met ($1,250 single/ $2,500 family in 2013).

**Will a debit card be issued with this FSA plan?** ☐ Yes ☐ No

## FSA Plan 2 (Please note, handwritten options or deviations from this application will not be accepted.) Group Number:__________

| Plan Year Start Date | Plan Year End Date | **Plan Year Run-Out End Date*:**__________<br>*Run-out is the number of days after the end of the plan year the FSA will continue to pay expenses incurred during the plan year. |
|---|---|---|

**Plan Year Run-Out Days for Terminated Employees:** ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ______ days

FSA will pay expenses for terminated employees incurred on or before the termination date if received within this number of days following the termination date. ☐ or by plan year run-out

**Grace Period Days:** ☐ 0 days ☐ 75 days ☐ Other _______ days (Cannot exceed 75 days.)

The FSA grace period provides an additional time period after the end of the plan year to incur expenses against the FSA.
This time period begins the first day following the end of the plan year.

**Grace Period Days for Terminated Employees:** ☐ 0 days ☐ 75 days ☐ Other _______ days (Cannot exceed 75 days.)

Election Minimum: $__________ Election Maximum: $__________

**FSA Plan Type(s):** ☐ Full Health Care FSA ☐ Limited-Purpose FSA (LPFSA)* If LPFSA, is it also post-deductible?** ☐ Yes ☐ No

*Limited dental, vision, preventative expenses
**If post-deductible, the LPFSA switches to a full health care FSA once the IRS deductible is met ($1,250 single/ $2,500 family in 2013).

**Will a debit card be issued with this FSA plan?** ☐ Yes ☐ No

## Dependent Care Reimbursement Account (DCRA) Plan (Please note, handwritten options or deviations from this application will not be accepted.)

| Plan Year Start Date: | Plan Year End Date: | **Plan Year Run-Out End Date*:**__________<br>*Run-out is the number of days after the end of the plan year the DCRA will continue to pay expenses incurred during the plan year. |
|---|---|---|

**Plan Year Run-Out Days for Terminated Employees:** ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ______ days

DCRA will pay expenses for terminated employees incurred on or before the termination date if received within this number of days following the termination date. ☐ or by plan year run-out date

## DCRA Plan (Cont.)

**Grace Period Days:** ☐ 0 days ☐ 75 days ☐ Other ________ days (Cannot Exceed 75 days.)

The DCRA grace period provides an additional time period after the end of the plan year to incur expenses against the DCRA. This time period begins the first day following the end of the plan year.

**Grace Period Days for Terminated Employees:** ☐ 0 days ☐ 75 days ☐ Other ________ days (Cannot exceed 75 days.)

Election Minimum: $____________________ Election Maximum: $____________________

## Payroll Information (applies to FSA/DCRA plans only, not HRA)

**Section I: Payroll Calendar** (not needed for HRA-only plans)

| | | |
|---|---|---|
| ☐ Weekly ☐ Biweekly-Weekly | ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri | |
| ☐ Semimonthly | ☐ Day _____ and day _____ of every month | **or the** ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ Last<br>☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri<br>**and the** ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ Last<br>☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri |
| ☐ Monthly | ☐ Day _____ and every _____ month(s) | **or the** ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ Last<br>☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri |

**Date of first payroll during new plan year:** ____________________

**Section II: How HealthEquity Will Track Individual Employee/Employer Payroll Deductions/Contributions** (not needed for HRA only plans)

☐ HealthEquity assumes payroll deductions/employee contributions according to payroll calendar and annual election amount. (Group will not send payroll details to HealthEquity.)

☐ Group will upload payroll deductions/contributions through employer portal according to payroll calendar.

## Employer Funding Options

To specify how you will send HealthEquity funds used to pay claims, select a funding option for each plan.
**(Note:** HIA accounts are funded only as employees complete qualified events.)

Would you like us to automatically debit (auto-debit) your account when claims invoices are generated? FSA: ☐ Yes ☐ No HRA: ☐ Yes ☐ No

☐ HRA

☐ **Option 1: Reserve Account Funding***

| Funding Frequency | Reserve Amount |
|---|---|
| ☐ Daily | Maintain 3% (auto-debit is required) |
| ☐ Weekly | Maintain 10% balance of annual plan liability without a debit card 15% with card |
| ☐ Monthly | Maintain 20% balance of annual plan liability (not available with a card) |

What day of the month do you want to receive a replenishment request e-mail notification?
☐ 1 (default) ☐ 15 ☐ 30 ☐ Other _______

☐ **Option 2: Pay-as-you-go (with auto-debit)**
Each day if claim(s) are payable, an invoice is generated and your account is auto-debited 2 business days later. (Not available with a debit card.)

☐ FSA

☐ **Option 1: Reserve Account Funding***

| Funding Frequency | Reserve Amount |
|---|---|
| ☐ Daily | Maintain 3% (auto-debit is required) |
| ☐ Weekly | Maintain 10% balance of annual plan liability without a debit card 15% with card |
| ☐ Monthly | Maintain 20% balance of annual plan liability (not available with a card) |

What day of the month do you want to receive a replenishment request e-mail notification?
☐ 1 (default) ☐ 15 ☐ 30 ☐ Other _______

☐ **Option 2: Pay-as-you-go (with auto-debit)**
Each day if claim(s) are payable, an invoice is generated and your account is auto-debited 2 business days later. (Not available with a debit card.)

☐ **Option 3: Payroll (DCRA only)**
Fund the account as deposits are withheld from payroll.

*** Reserve account funding:** Based on total annual plan liability and the frequency of funding, HealthEquity requests a percent to be held on the employer's behalf as a reserve. As claims are processed each day, HealthEquity pays them from this reserve fund. Employer receives a replenishment request e-mail notification (according to funding frequency) asking that the reserve amount be brought back up to the target percentage. This method provides the fastest means of claims payment and is preferred. If at any time, funds are not available for payable claims, employers receive an e-mail notification of pending claims invoices that require payment through the HealthEquity employer portal.

****Payroll deposits:** Employers wishing to fund their plan liability in coordination with their payroll select this option. Using the deduction wizard on HealthEquity's employer portal, employers upload a file or enter amounts in the interface for the amount they wish to deposit. An invoice is generated and viewable on the portal for these deposit amounts. Funds on deposit are used daily to pay claims. If at any time, funds are not available for payable claims, employers receive an e-mail notification of pending claims invoices that require payment.

## Multiple Account Hierarchy

If multiple accounts are offered, indicate the order to use accounts to pay claims. This applies to all transactions, including debit cards. If a zero balance is reached in the primary account, the secondary account will be used.

**1 - Pays First  2 - Pays Second  3 - Pays Third**  HRA ____ FSA ____ HIA ____

## Co-Pay Matching

To assist with substantiation, please provide all co-payment amounts associated with your medical plan, including all medical, dental, and/or Rx, which can be provided by attaching the medical benefit summary.

## Nondiscrimination Testing

**Will you need nondiscrimination testing performed for your plan?:** ☐ Yes* ☐ No

If yes, you will need to provide HealthEquity additional eligibility information for each of your participants (ownership %, officer status, compensation, etc.). HealthEquity will provide additional instruction at the time your group is set up.

* Available one time a year at no additional cost.

**Would you like updated plan documents? (Only needed if making changes from prior plan year.)** ☐ Yes ☐ No

## Debit Card Plan Designs for HRA Accounts

| Expenses on the Card | Expenses in the HRA | Auto-pay Allowed? |
|---|---|---|
| 213(d) | 213(d) | No |
| Rx Only | Deductible/Copay/Coinsurance | Yes on eligible medical claims |

Note: Debit card is allowed when the HRA pays first without any payment caps. Your HealthEquity representative will advise wheather your deisgn works with a debit card.

## Banking Information

The following banking information will be used for the initial funding and ongoing replenishment of the reserve account.
***Please include a copy of a voided check to verify this banking information.***

| Bank Name | Bank Address |
|---|---|
| Bank Phone | Account Type |
| Routing Number | Account Number |
| Person Authorizing | Phone Number |
| Signature | |

## Signature

**I hereby authorize HealthEquity to provide reimbursement account services based on the information provided in this application.**

| Print Name | Date |
|---|---|
| Signature | |

After completing this form, please date and sign above, then scan and e-mail to raclientservices@healthequity.com or fax to 801.407.1792.

We will send an email to the plan contact and an email to the sender confirming receipt of the application.