HRA Data Form

DataPath Administrative Services

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

Plan Elections

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

please proceed to page 2

continued from page 1

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 $ _____ per plan year

☐ 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

Plan Design

Deductible _____

Dollar Amount	Participant Pays %	HRA Pays %
$0 -		

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

please proceed to page 3

continued from page 2

Reimbursement Frequency

☐ **Daily** (claims processed and paid on the business day following the business day on which DataPath Administrative Services receives claim)
☐ **Weekly on** _____ (day of week) ☐ **Monthly on**_____ (day of month)
☐ **Per Pay Period** (Bi-Weekly or Semi-Monthly) ☐ **Other**_____

Reimbursement Methods

☐ **mySourceCard® debit card** (available only "first-dollar" plan designs)
☐ **ACH Deposit plus Direct Checks** (checks mailed by DataPath Administrative Services direct to participants)
☐ **ACH Deposit plus Employer Batch Checks** (checks mailed by DataPath Admin. 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

Internal Use Only
Add ❑ New ❑ Employer Info key ❑ ER Label _____
Banking ❑ Arvest (125 & CMS) ❑ Other (CMS Only)
Use ID Protection for individual Employee ID ❑ Yes ❑ No
On hold for payment processing ❑ Yes ❑ No