



CHECKLIST

Section 105 - Health Reimbursement Arrangement

EMPLOYER INFORMATION

1. EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER (Plan Administrator)

Name: _____

Address: _____

City State Zip

Telephone: _____ Fax: _____

HR Contact: _____ PR Contact: _____

Email Address: _____

2. EMPLOYER'S TAXPAYER IDENTIFICATION NUMBER: _____

3. TYPE OF ENTITY

- a. Corporation (including Tax-exempt or Non-profit Corporation)
b. Professional Service Corporation
c. S Corporation
d. Limited Liability Company that is taxed as:
1. Partnership or Sole Proprietorship
2. Corporation
3. an S Corporation
e. Sole Proprietorship or Non-profit Corporation
f. Partnership (including Limited Liability)
g. Governmental Entity
h. Other

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Health Reimbursement Arrangement.

PLAN INFORMATION

4. PLAN NAME: _____

5. EFFECTIVE DATE

- a. This is a new Health Reimbursement Arrangement effective as of (hereinafter called the "Effective Date").
b. This is an amendment and restatement of a previously established Health Reimbursement Arrangement of the Employer which was originally effective (hereinafter called the "Effective Date"). The effective date of this amendment and restatement is.

6. PLAN YEAR: _____ (ie: January 1 to December 31)

If applicable- Deductible year (plan year): Open Enrollment Month: Renewal Month:

7. IS THIS A SHORT PLAN YEAR?

- a. No.
b. Yes, dates of short plan year: _____ (ie: January 1, 2012 to June 30, 2012)

If this is a short plan year and there is a HRA deductible:

- a. No carryover deductible
b. Allow carryover deductible - Must include a report from health insurance plan for deductible expenses prior to the start of the short plan year for the HRA.

8. NUMBER assigned by the Employer

- a. 501
- b. 502
- c. 503
- d. Other: _____

9. CLAIMS ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:

(If none is named, the Employer will serve as the Claims Administrator.)

- a. Employer (Self-Administered. Use Employer address and telephone number).
- b. Use name, address and telephone number below:

Name: _____

Address: _____

City State Zip

Telephone: _____

ELIGIBILITY REQUIREMENTS

10. ELIGIBLE EMPLOYEES

- a. N/A. No exclusions.
- b. The following are excluded (select all that apply):
 - 1. Union Employees
 - 2. Non-resident aliens
 - 3. Salaried Employees
 - 4. Hourly Employees
 - 5. Leased Employees
 - 6. Part-Time Employees scheduled to work less than _____ hours per week.
 - 7. Other: _____

11. ARE DEPENDENTS COVERED?

- No
- Yes - *If HRA deductibles/maximums need to be tracked for #17 below, you must provide dependent information on the enrollment form.*

12. DEPENDENT DEFINITION. Default language in the Plan Document for the definition of dependent includes older children referenced in IRS Notice 2010-38 (April 27, 2010), which allows the expenses of adult children, up to age 27, to be reimbursed through their parents' Health Reimbursement Arrangement.

Check here if you do not want to allow adult children to be covered under your Health Reimbursement Arrangement.

13. THE FOLLOWING AFFILIATED EMPLOYERS will adopt this Health Reimbursement Arrangement as Participating Employers (if there is more than one, or if Affiliated Employers adopt this after the date the Adoption Agreement is executed, attach a list to this Adoption Agreement of such Affiliated Employers including their names, addresses and taxpayer identification numbers):

- a. N/A
- b. Name of Affiliated Employer (s): _____

Address: _____

City State Zip

TIN: _____

14. CONDITIONS OF ELIGIBILITY

Any Eligible Employee will be eligible to participate in the Health Reimbursement Arrangement upon satisfaction of the following:

- a. Date of Hire (No service required)
- b. _____ years after date of hire
- c. _____ months after date of hire
- d. _____ days after date of hire
- e. Other: _____

15. EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee who has satisfied the eligibility requirements will become a Participant on:

- a. the day on which such requirements are satisfied.
- b. the first day of the month coinciding with or next following the date on which such requirements are satisfied.
- c. the first day of the calendar quarter coinciding with or next following the date on which such requirements are satisfied.
- d. the first day of the pay period coinciding with or next following the date on which such requirements are met.
- e. the first day of the Coverage Period coinciding with or next following the date on which such requirements are satisfied.
- f. Other: _____

BENEFITS

16. THIS ARRANGEMENT SHALL REIMBURSE: (select all that apply)

- a. Co-payments under the Employer’s group medical plan (must provide EOB)
- b. CO-INSURANCE under group medical plan (must provide EOB)
- c. All out of pocket expenses on the Employer’s group medical plan (must provide EOB)
- d. Deductibles under the Employer’s group medical plan (add deductible amounts in the table below)

Please note the name of the Group Health Insurance plan if checking any boxes under a. b. c. or d.

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- e. All medical expenses within the meaning of Code Section 213
 - f. Prescription co-pay amounts (not included on EOB)
 - g. Medical insurance premiums
 - h. The following types of medical expenses ONLY: _____
 - i. Other: _____

17. MAXIMUM BENEFIT PER COVERAGE PERIOD (complete table below):

	Per Participant	Per Participant & Spouse/Dependent		Per Family	
		Each	Maximum	Each	Maximum
Insurance Deductible (if d. is checked above)	\$	\$	\$	\$	\$
Member’s responsibility before HRA pays (HRA DEDUCTIBLE) <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	\$	\$	\$
PERCENTAGE HRA PAYS:	%	%	%	%	%
Total HRA Benefit	\$	\$	\$	\$	\$
ADDITIONAL BENEFIT INFORMATION					

18. IF THE EMPLOYER MAINTAINS A HEALTH FLEXIBLE SPENDING ACCOUNT, WHICH PLAN SHALL PAY EXPENSES FIRST?

- a. N/A. The Employer does not maintain a Health Flexible Spending Account and/or Cafeteria Plan.
- b. This Plan (Health Reimbursement Arrangement).
Automatically roll the HRA out of pocket amount to an existing Flexible Spending Account @ ABPM
 - YES
 - NO
- c. The Health Flexible Spending Account under the Employer's Cafeteria Plan.

OTHER PLAN INFORMATION

19. IS THE EMPLOYER SUBJECT TO THE FAMILY AND MEDICAL LEAVE ACT?

If b. is selected, FMLA will not apply.

- a. Yes.
- b. No.

20. IS THE PLAN SUBJECT TO COBRA?

If b. is selected, COBRA will not apply.

- a. Yes.
- b. No.

20a. Allegiance offers HRA COBRA administration. After one (1) year of claims experience, we can calculate a HRA per month premium for an additional fee. Do you want Allegiance to administer your COBRA Services?

- a. Yes. I understand that the HRA COBRA premiums for the first year will be free.
- b. Yes. The first year HRA monthly premium amount for HRA COBRA is \$ _____.
- c. Yes. Other
- d. No.

21. COVERAGE PERIOD is:

- a. yearly with contributions posted monthly.
- b. yearly, with full annual balance available at any time during the plan year.
- c. Other _____

22. CLAIM Payout:

- a. Pay up to what is accrued in the participants account.
- b. Pay up to the participants annual fund balance.

23. CARRY FORWARD: Amounts not used during a Coverage Period shall:

- a. Be carried forward to the next Coverage Period, in an amount up to \$ _____.
However, the maximum accumulation limit for a Coverage Period is \$ _____.
- b. Be forfeited.

24. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN:

_____ days following each coverage period.

25. RETIREES OR OTHER TERMINATED EMPLOYEES SHALL:

- a. Shall continue to be eligible for reimbursement of any remaining balances.
- b. Participation ceases at termination.
A CLAIM may be submitted up to _____ days after
 - a. the end of the Coverage Period.
 - b. the termination date.
 - c. Other: _____

26. **How would you like to fund HRA reimbursements? FUNDING FROM THE PLAN SPONSOR will occur**
- a. **A request for funding will be sent on the 15th and 30th of each month**
Can Allegiance electronically withdraw funds?
 No
 Yes (if yes, please complete, sign and initial the attached ACH Debit Authorization Form)
- b. **Send an advance – Allegiance will release funds on the 15th & 30th up to the advanced amt.**
(To set up this process, please contact the HRA funding specialist in Allegiance flex accounting at 1-877-424-3570 ext 4601.)

- 26a. **HRA Funding Notifications- sent to you by**
- a. **E-mail address:** _____ **Attn to:** _____.
- or
- b. **Fax Number:** _____ **Attn to:** _____.
- Comments:** _____

27. **INSTANT PASSWORDS for participant website access (when applicable):**
- a. **Yes**
- b. **No**

28. **FEE SCHEDULE**
 Initial Set-Up Fee \$ _____
 Annual Enrollment Fee \$ _____
 Each Participant per Month \$ _____
 Minimum Monthly Fee \$ _____

COBRA Services Fee Schedule

Initial Set-Up Fee \$ _____
 HRA COBRA calculation Fee \$ _____
 Annual Enrollment Fee \$ _____
 COBRA fee Per Event Fee \$ _____ or PPPM \$ _____

29. Agent Name: _____
 Agency Name: _____
 Address: _____

 City State Zip
 Agent E-Mail Address: _____ Telephone: _____
 Fax: _____ TIN: _____

These documents are being printed by Allegiance Benefit Plan Management, Inc., at the direction of the Employer named on the checklist form, under the supervision of an attorney. It is understood that Allegiance Benefit Plan Management, Inc., is not engaged in the practice of law. Any unanswered questions may result in errors in the Plan produced by using the information from this worksheet. I understand that in preparing the document requested, Allegiance Benefit Plan Management, Inc., is utilizing information shown on this checklist to produce legal documents using a format which has been designed by Allegiance Benefit Plan Management, Inc., with advice and assistance of its attorneys. Allegiance Benefit Plan Management, Inc., has made **NO REPRESENTATION OR WARRANTY OF ANY KIND**, expressed or implied, including no warranties of **MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE**, nor is any opinion, expressed or implied, rendered by its attorneys as to the legal effect, sufficiency or tax qualification of any document utilizing Allegiance Benefit Plan Management, Inc., format. It is understood and agreed that the documents must be reviewed and approved by the Employer's tax and legal counsel and that neither Allegiance Benefit Plan Management, Inc., or its attorneys and accountants are acting as legal or tax advisors to the Employer. I hereby **RELEASE** Allegiance Benefit Plan Management, Inc., and its attorneys from any and all liability attributable to any legal or other defect in the requested documents.

The cafeteria plan rules (Treasury regulations) require that a signed Plan Document must exist prior to providing benefits. A draft document will be provided to you for signature, based upon the benefit design indicated in this checklist. By your signature below, you certify that the benefit design above is correct and accurate. Allegiance will process claims based upon this design until a signed plan document is received. If modifications are made to this design after claims have been processed, which require Allegiance to reprocess claims, a fee of \$20 per claim reprocessed will be assessed.

Authorized signer: _____ Date: _____



DEBIT AUTHORIZATION

Please fill out and return with a voided check from your checkbook or withdraw slip from your savings account.

I authorize ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. and the Financial Institution listed below to initiate electronic withdrawal from Checking Account or Savings Account (please check one) in conjunction with services provided pursuant to the Administrative Services Agreement between ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. and the undersigned Company (“Company”). This authority will remain in effect until canceled in writing or until the termination or expiration of the Administrative Services Agreement referenced above, whichever comes first.

The weekly or monthly deduction amount will be communicated to Company in accordance with the Administrative Services Agreement as amended.

The authorization is to remain in full force and effect until Allegiance Benefit Plan Management, Inc., has received written notification from Company of its termination in such time and in such manner as to afford Allegiance Benefit Plan Management, Inc., and its Bank or other depository, a reasonable opportunity to act upon such termination.

All notices and communications to Company will be to the following address, telephone number and email:

Company Name:	Financial Institution:
Name (Please Print):	City/State:
Authorized Signature:	Account Number:
Date:	Routing and Transit Number:
Initials:	

On behalf of Company, I understand that Allegiance Benefit Plan Management, Inc., may initiate a reversal of any entry made under this agreement if an error has been made. I understand that the financial institution at which I have the above account is required to provide to me the procedures for resolving errors on entries made under this agreement. I understand that Allegiance Benefit Plan Management, Inc., will provide a written notice to me of the error within 24 hours.