Health Reimbursement Account Installation Questionnaire

EMPLOYER INFORMATION:

1. Employer (legal business name with correct punctuation): ______________________________________
   *(**NOTE:** A corporate name must end in "Incorporated", "Corporation" or "Limited", or an abbreviation of same)*

2. Street Address: ______________________________________

   City, State, Zip Code: ______________________________________

3. Contact Information:

	Contact #1	Contact #2	Contact #3
Name			
Title			
Phone			
Fax			
E-mail			
Accounting Contact	Yes / No	Yes / No	Yes / No

4. Tax ID Number:

		-							

5. Number of Eligible Employees: _______ Number of Employees World-Wide: _________

6. Type of Business Entity:

	Sole Proprietorship		Partnership or LLP
	Corporation		Non-Profit
	S- Corporation		LLC
	Government Entity		Other:

***Note:** The following individuals may not be in a Section 125 or Section105 plan:*
Sole Proprietors, Partners in a Partnership or an LLP, Shareholders in an LLC that is taxed as a Partnership and Shareholders in an S-Corp. that own more than 2% of the S-Corp.'s stock directly or through a related party.

7. Primary Industry: ______________________________________

8. Other than the entity identified in '1' above, please list the name, address and employer identification number of any other employers whose employees are to be eligible for this Plan:

NAME	ADDRESS	TAX ID

PLAN INFORMATION:

9. Plan Effective:

☐ New Pro-Flex Client – NEW Health Reimbursement Account will go into effect: ______/_______/____
Effective date of original plan: ________/_______/_______

☐ Plan Update/Amendment- Effective Date of the new documents: _______/_______/_______
Effective date of original plan: ____ /_____ / ____

10. Plan number to be used: ___________
(If no plan number is requested, a default plan number 501 will be used)

11. Initial Plan Year: ____ /_____ to ____ /_____

12. Will there be a short plan year?
☐ Yes ☐ No
If yes, short plan year begins_____ /_____/_____ and ends _____ /_____ /_____

Are the plan contribution amounts to be pro-rated for a short plan year?
☐ Yes ☐ No

ELIGIBILITY:

13. Eligible employees:
☐ N/A - No exclusions
☐ Employees enrolled in medical plan only *(skip to Plan Benefits section)*
☐ Retirees *(skip to Plan Benefits section)*
☐ The following employees are excluded from eligibility:
  ☐ Non-resident Aliens
  ☐ Employees in-eligible for the employer's health plan
  ☐ Salaried Employees
  ☐ Hourly Employees
  ☐ Leased Employees
  ☐ Union employees
  ☐ Employees who are regularly scheduled to work less than ______ hours per week
  ☐ Other – describe:___________________________
  ☐ Employees in the following job categories: ____
  ☐ Retirees

14. The minimum service requirement to participate:
☐ N/A - No minimum service requirement
☐ _______days after date of hire
☐ _______months after date of hire
☐ Other: ____

15. Upon completion of the above, the employee becomes effective:
☐ Immediately
☐ First of the month following
☐ Other: ____

PLAN BENEFITS:

16. HRA Plan Design:
    - ☐ Un-restricted: Plan will allow all medical/dental/vision/OTC expenses under IRS Section 213(d)
    - ☐ Restricted: Plan will restrict expenses to: (please check all that apply)
        - ☐ Medical Deductible Expenses ONLY
        - ☐ Medical and Prescription Deductible Expenses
        - ☐ Medical and Prescription Deductible, Co-pay and Co-insurance Expenses
        - ☐ Medical Deductible and Co-pay and Coinsurance Expenses
        - ☐ Prescription Expenses ONLY
        - ☐ Qualified Small Employer
        - ☐ Other:___________________________________

17. HRA Allowance:
    - ☐ $_______ per employee
    - ☐ $_____ Single $_____ Two Person $_____ EE+ Child(ren) $______ Family
    - ☐ Other $_______

18. Will the member be required to meet an out of pocket deductible before the HRA kicks in?
    ☐ Yes, $_______ (single) / $________ (all other tiers) ☐ No

19. Will claims be reimbursed at a rate of 100%?
    ☐ Yes ☐ No, reimburse at _________%

20. Contributions will be made available to members:
    - ☐ Annually- On the first day of the plan year
    - ☐ Quarterly- On the first of the month each quarter for all plan years
    - ☐ Monthly- On the first of the month each moth for all plan years
    - ☐ Other (Describe):____

21. Will the HRA contributions be pro-rated for any new hires /qualifying events occurring mid plan year?
    ☐ Yes ☐ No

CLAIMS SUBMISSION:

22. Will this plan allow for use of the Pro-Flex Payment Card?
    ☐ Yes ☐ No

    If yes, what return address would you like used on the Pro-Flex Payment Cards?
    ☐ Pro-Flex ☐ Employer

23. Does the employer offer a Health Savings Account (HSA)?
    ☐ Yes ☐ No

24. Does the employer offer a Flexible Spending Account (FSA)?
    ☐ Yes ☐ No

For plans where Pro-Flex Administrators, LLC is administering both the FSA/HSA and HRA, which plan should pay first?

☐ FSA/HSA ☐ HRA

25. Claims "run-out" period: (check all that apply)
   - ☐ _______days after the end of the plan year/after last date eligible
   - ☐ Roll-Over HRA

     If Roll Over: ☐ Rollover up to $_______ of unused funds
     ☐ Rollover 100% of unused funds
     ☐ Rollover ____% of unused funds

MISC:

26. How will the client remit fee payments to Pro-Flex Administrators, LLC?

   ☐ Manual Check ☐ ACH Withdraw *(Client will need to complete Electronic Payment Authorization)*

27. Will the client require divisional reporting?

   ☐ Yes ☐ No

   If yes, please list the division names:____

28. For payment of claim reimbursements:

   ☐ Pro-Flex Administrators will ACH funds from the employer's bank account *(This is the only option for Debit Card clients- **Complete Bancorp ACH Authorization for Debits/Credits**)*

   ☐ Client will ACH funds to Pro-Flex's bank account *(Client will need Pro-Flex Banking Information- **additional costs will apply**)*

   In both cases the employer will be provided with a listing of claims paid in a check register report

29. How often will claims be paid?

   ☐ Every business day *(This is option requires a 3% collateral deposit for debit card issuance)*

   ☐ Weekly on Monday *(This is option requires a 5% collateral deposit for debit card issuance)*

30. Will Pro-Flex be administering the run out on the current plan year?

   ☐ No, the current TPA will handle their own run-out period. *(Pro-Flex preference)*

   ☐ Yes, Pro-Flex will handle the current plan year run-out. *(Client to send Pro-Flex a final balance report once final claims have been paid)*

Client Signature: ____ Date:______________________

****Please note:** Signature on this document is an agreement to pay Pro-Flex Administrators LLC all applicable fees described in detail in the proposal. Failure to pay fees may result in a halt of implementation or claims reimbursements to employees. If implementation has already begun, and a change is made, amendment fees may apply.*

BROKER INFORMATION:

Agency Name: ____

Contact Name and Title: ____

Signature: ____ Date:_____________________

Submit to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221

AUTHORIZATION FOR ACH DEBITS / CREDITS

____

Depositor Name as Shown on Bank Records

____

Checking Account Number/ Transit Routing Number

(A voided check, letter from the bank verifying the account AND routing number or MICR spec sheet must be attached for this account)

TO: ____

____

(Bank Address: Street, Box #, City, State and Zip Code)

Depositor authorizes The Bancorp Bank to present automated debits and credits to and from the above listed account as required to perform their responsibilities related to processing Depositor's benefit program. This authorization will remain in effect until revoked by Depositor in writing and until you actually receive such notice Depositor agrees that you shall be fully protected in honoring any such ACH transaction.

Depositor agrees that your treatment of each such ACH transaction and your rights in respect to it shall be the same as if it were a check signed by Depositor.

I authorize payments to be withdrawn daily or weekly as needed.

Dated this______day of____________, 20_____.

____

Signature of Depositor in Agreement with Bank Records

Please update your ACH filter (on the above reference account) to grant access to The Bancorp Bank. The Bancorp Bank identification number is: **1050006509**.

Electronic Payment Authorization

______**Pro-Flex Administrators LLC**___ , provides benefit administration services to____ and/or, one or more of its wholly owned subsidiaries.

___________________________________ desires the flexibility to make payments for such services by electronic funds transfers (EFT) through the ACH Network.

Therefore, ____hereby (1) authorizes Pro-Flex Administrators LLC to receive payments for services by EFT, (2) certifies that it has selected the following depository financial institution, and (3) directs that all such electronic funds transfers be made as provided below:

Depository Institution Name: _______________________________________

Routing Transit Number: ____

Account Number: ____

ACH Payment Format: CCD will be used (Cash Concentration/Disbursement)

Company EFT Contact: ____

Company Telephone Number: ____

____ acknowledges and agrees that the terms and conditions of all agreements with Pro-Flex Administrators LLC concerning the method and timing of payments for services shall be amended as provided herein.

Company will give thirty (30) days advanced, written notice to Pro-Flex Administrators LLC of any changes in depository financial institution or other payment instructions.

When properly executed, the Authorization will become effective fifteen (15) days after its receipt by Pro-Flex Administrators LLC.

NAME OF COMPANY: _______________________________________

BY: ____

TITLE: ________________________________ DATE: ________________