Flex EB-HRA | Excepted Benefit HRA plan

Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Flex EBHRA document package. It is a fillable PDF form. Click on the line next to "First Name" to begin and then tab from field to field.

Purchaser Information (Person buying document for Employer listed below, i.e. Agent, CPA, payroll co., etc.; "N/A" in "First Name" if not applicable.)

First Name _____ Last Name _____
Company _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Mobile _____ Fax _____
Email _____ Web site _____
Ship Plan Document package to: ☐ Purchaser ☐ Employer

Employer Information for Plan Documents

(Owner/controller, document signer; exactly as it should appear in the plan document.)

First Name _____ Last Name _____
Company _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Mobile _____ Fax _____
Email _____ Web site _____

Form of Business: ☐ S Corporation ☐ C Corporation ☐ LLC ☐ Partnership ☐ Sole proprietors hip ☐ Government ☐ Non-Profit 501(c)

Employer Fed. ID # (3) _____ State of Incorporation _____ No. of Employees _____

Legal Name(s) of **Affiliated Company(ies)** that will be covered by the Plan (if any):

1) _____
2) _____
3) _____

Plan Administrator

☐ Employer (use 'employer' information, above) ☐ Other (provide information below)

First Name _____ Last Name _____ Company _____ Address _____ City _____ State _____ Zip Code _____
Phone _____ Email _____

Effective Date

☐ A new plan with an effective date of _____.
☐ Amend and restate an existing EBHRA plan as of _____.

If this is an amended and restated plan, state the (old) original effective date: _____.

Plan Year The first plan year will be:

☐ A 12-month consecutive period beginning date _____ and ending date _____.
☐ A short plan year beginning date _____ and ending date _____.

Waiting Period Employees are allowed to participate in the plan: ☐ on the 1st day of employment, or ☐ the 1st day following, or ☐ the first day following _____ days of employment.

Eligibility Requirements: All employees who work _____ or more hours per week.

Please tell us how you found us: ☐ Search Engine ☐ Agent ☐ Google Ad ☐ Other _____

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Employer:_____

Choose either the HRA 'Deluxe Binder Option' or the 'Basic PDF Option':

◉ **Deluxe Binder – New EB-Health Reimbursement Arrangement Plan Document**

In email PDF version processed ASAP, AND printed in a 3-ring binder with 5-section tabbed index, shipped via Priority Mail.

OR

○ **Basic PDF Option - New EB-Health Reimbursement Arrangement Plan Document**

PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the EBHRA Deluxe Binder or the Basic PDF Option:

☐ **Plan Document CD Mailed - in addition to PDF email and/or mailed binder**
Documents provided in PDF format only. Forms in MS Word format.
Always have a safe backup copy of your plan document on CD.

☐ **Rush Order fee - Your order automatically queued for immediate processing**

☐ **2nd Year Update - discounted when added to new document order**
This option entitles you to one plan document amendment in the first 24 months.
Save off the normal full update price.

Update and Amend an EBHRA plan document originally produced by us:

☐ **Update/Amend EB-Health Reimbursement Arrangement HRA Plan Document**
All Updated/Amended documents delivered via email in PDF format.

TOTAL _____

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Employer:_____

EBHRA Plan Design

Please answer all of the following basic design questions that will apply to the EBHRA benefit that you would like to the EBHRA benefit that you would like to provide. A Flex Benefit Consultant will contact you regarding your custom plan design requests, issues, and design criteria.

Do you offer a traditional group health insurance plan? ☐ **Yes** ☐ **No**

EB HRA Coverage:
☐ Coverage will be available to Employees Only
☐ Coverage is available to Employee & Employee + Dependents

Benefit Availability:
☐ Monthly
☐ Lump Sum/Annual (available on day 1)

Benefit Limits:
☐ Use the indexed annual maximum IRS allowed EBHRA benefit of $1,800 in 2020.
☐ Limit the EBHRA annual benefit as specified below:

Benefit Limit by Coverage Type:
Please enter annual benefit limits for Employee as well as Employee and Eligible Dependents.
☐ Employee Only (annually) $_____
☐ Employee & Eligible Dependents (annually) $_____

EB HRA Reimbursement Type(s) allowed:
Please check all Excepted Benefits to be reimbursed:
☐ Limited scope dental and vision insurance
☐ COBRA continuation coverage
☐ Short-term limited duration insurance (STDLI)
☐ Cost sharing (co-pays and deductible)
☐ Long-term care coverage (nursing home care, home healthcare, community-based care, or any combination thereof.

Carryover of Unused Funds:
Are unused HRA funds allowed to carry over to the next Plan Year? ☐ Yes ☐ No

EBHRA Plan Design Notes: (Please use the box below)

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Employer:_____

If paying by check, please complete the following:

Name as it appears on check:

_____

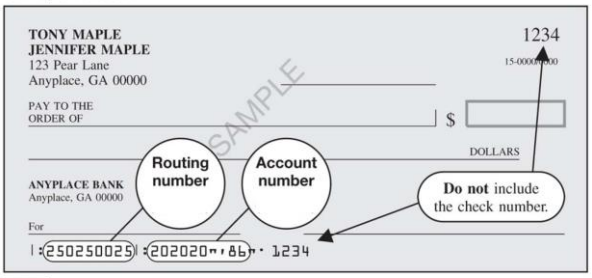
Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____

Sample Check



CAUTION *The routing and account numbers may be in different places on your check.*

X_____ Date: _____
Signature

If paying by credit card, please complete the following:

Card Type: r Discover r VISA r MasterCard r American Express

Card Number: _____ _____ _____ _____

Expiration Date: ____ /____

3 Digit Security Code on back:_____
(4 digit on American Express front)

Security Code

Total amount to be charged: $_____

Name as it appears on card: _____

X_____ Date: _____
Signature

Refund Policy: Purchaser understands that goods and services provided are non-refundable. Orders canceled prior to sending/shipping are subject to cancellation fees applied to the cost of goods and services provided during the review, draft, and preparation of your order