Flex IC-HRA | Individual Coverage HRA plan

Individual Coverage HRA Plan Document: Ordering Information

This form is provided for your convenience while gathering information for the Core IC-HRA 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 Proprietorship ☐ Government ☐ Non-Profit 501(c)(3)

Employer Fed. ID #_____ 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 _____

Protected Health Information Designee

(The person who will be responsible for the proper handling of medical information protected under HIPAA law.)

Name _____

ICHRA Effective Date

☐ A new plan with an effective date of_____.

☐ Amend and restate an existing ICHRA 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_____.

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

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Employer:_____

ICHRA PLAN DESIGN

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

Employee Eligibility

Waiting Period Employees are eligible to participate in the plan on:

☐ the 1st day of employment, or ☐ the 1st day following, or ☐ the 1st day of the month following _____ days of employment.

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

ICHRA Options

Check all that apply:

__ Coverage will be available to Employee Only

__ Coverage is available to Employee & Employee + Dependents

__ ICHRA reimburses IC premiums only

__ ICHRA reimburses IC premiums plus all allowed IRS 213(d) medical, dental, vision expenses

__ Reimburses Medicare Premium Parts B, C, and D and supplemental coverage

__ Reimburses Medicare out-of-pocket expenses including all allowed IRS 213(d) medical, dental, vision expenses

__ ICHRA will coordinate with a Health FSA

__ ICHRA will coordinate with an HSA

Annual ICHRA benefit amounts

$_____ (annually) for employees with self-only health insurance coverage

$_____ (annually) for employees with eligible dependents (with family coverage)

Benefit Availability

☐ Monthly and prorated

☐ Lump sum available on day 1 of Plan Year

End-of-Year Carryover

Will unused ICHRA funds rollover to the next plan year? __Yes __No

What percentage of the unused balance will carryover at the end of the year? __100% __Other (_____%)

Pre-tax Balance of Premium Salary Deductions

Will employees be able to make payments for balance of IC premium to insurance provider via pre-tax salary deductions in a Section 125 Premium Only Plan?[1, 2, 3] __Yes __No

[1]This option requires a newly-adopted Section 125 Plan document ($99 fee).

[2]Premium for IC purchased on an exchange is *not eligible* for balance-of-premium payments through a Section 125 pre-tax plan.

[3]We will contact you about additional ways to reduce payroll taxes and make employee excess premium more affordable.

Benefit Amount for Older Employees

Will premium reimbursement be the same for all ages? __Yes __No

If "No" and you are using an age-rated or banded or rates by class of employee, please provide us with the rate structure by class of employee in either MS Word or PDF as this information must be included on the ICHRA Notice to Employees, Plan Document, and Summary Plan Description Schedule of Benefits (SPD).

Benefit Defined by Employee Class

Will your ICHRA offer different Benefits by Employee Class or Location? __Yes __No

If the answer is" Yes," please provide your proposed Class definitions for the Plan Year using MS Word or PDF formatting. *(Section continues on next page.)*

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Employer:_____

Please enter additional plan design notes below:

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

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

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

OR

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

PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the IC-HRA 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 - Your order automatically queued for immediate processing**

☐ **2nd Year Update - discounted 25% when added to new document order**

This option entitles you to one plan document amendment in the first 24 months.
Save 25% off the normal update price.

Update and Amend an IC-HRA plan document originally produced by us:

☐ **Update/Amend IC-Health Reimbursement Arrangement HRA Plan Document**

All Updated/Amended documents delivered via email in PDF format.

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Employer:_____

If paying by check, please complete the following:

Name as it appears on check:

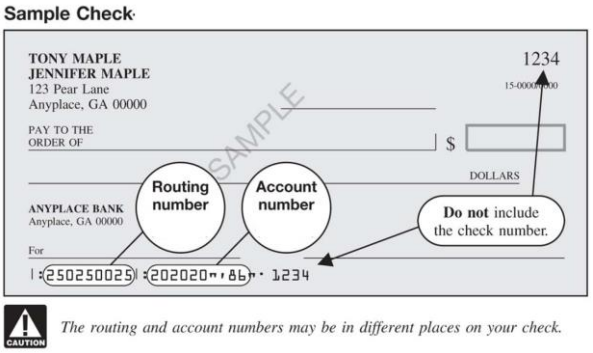
_____

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____



X_____ Date: _____
Signature

If paying by credit card, please complete the following:

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

Card Number: _____ _____ _____ _____

Expiration Date: ____ /____

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

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.