Health Reimbursement Arrangement
New Client Application

SECTION 1: EMPLOYER DEMOGRAPHIC INFORMATION

Plan Sponsor Name			**Tax ID**	
Street Address	**City**		**State**	**Zip**

SECTION 2: EMPLOYER CONTACT INFORMATION

Human Resources		**Accounts Payable**	
Name		**Name**	
Title		**Title**	
Phone		**Phone**	
Email		**Email**	

SECTION 3: HRA PLAN DESIGN

HRA Plan Type	☐ Integrated with Group Insurance	☐ Qualified Small Employer (QSEHRA)
	☐ Limited Purpose Dental/Vision	☐ Individual Coverage (ICHRA)
	☐ Retiree HRA	☐ Other/Custom

HRA Plan Start Date		**Initial Short HRA Plan Year**	☐ Yes
HRA Plan End Date			☐ No
HRA Plan Run-Out Date		**HRA Plan Run-Out Days for Terminated Employees**	☐ 90 Days
Open Enrollment End Date			☐ Other
New HRA Plan or Existing HRA Plan Transferred from Another Administrator	☐ New	**Vendor Responsible for Claims Run Out for Current Plan Year**	☐ Marin Benefits (fees apply)
	☐ Transferred New Plan Year		☐ Current Administrator
	☐ Transferred Mid Plan Year	**Transfer Effective Date**	

SECTION 4: BENEFIT DEBIT CARDS

HRA Benefit Card Program (Subject to Plan Design)	☐ Yes	**Ship Cards To**	☐ Member
	☐ No		☐ Employer
Dependent Cards	☐ Issue Cards for Spouse/Domestic Partners Only		
	☐ Issue Cards for All Dependents Over Age 18		
	☐ Do Not Issue Cards for Dependents		

SECTION 5: ENROLLMENT PROCESSING

Regular Enrollment Provided By	☐ Manually Via Secure Email	**Vendor Name**	
	☐ Vendor	**Vendor Email**	

SECTION 6: COBRA ADMINISTRATION

COBRA Enrollment Provided By	☐ Manually Via Secure Email	**Vendor Name**	
	☐ Vendor	**Vendor Email**	

SECTION 7: PARTICIPANT ELIGIBILITY

Employee Eligibility:

☐ An employee who is regularly scheduled to work a minimum of _____ hours per week

☐ Other ____

Eligibility Date:

☐ The first regularly scheduled working day on which the employee performs service for the employer for compensation

☐ First day of the month following _____ days of continuous employment with the employer

☐ Other ____

Benefits Terminate:

☐ On the day in which the employee ceases to be an eligible employee. Claims must be filed within 90 days of separation

☐ On the last day of the month in which the employee ceases to be an eligible employee. Claims must be filed within 90 days of separation

☐ Other ____

Eligibility Criteria:

☐ Eligibility criteria are the same as the employer's insurance plans that are group health plans

☐ Eligibility criteria are NOT the same as the employer's insurance plans that are group health plans

Dependents covered by the plan:

☐ No Dependents

Or

☐ Spouse

☐ Domestic Partner

☐ Dependent Children to age _____

☐ Dependent Children of any age who depend on employee for support due to physical or mental disability

☐ Other ____

Employee Classification:

☐ Employees do not need to be assigned to a division for the HRA based upon their employment location or classification

☐ Employees need to be assigned to a division for the HRA based upon their employment location or classification

Other/Miscellaneous Eligibility Criteria:

SECTION 8: HRA CONTRIBUTIONS

Employer Contribution:

☐ Annual Benefit $__________ per Employee Only
$__________ per Employee + 1 Dependent
$__________ per Employee + 2 or more Dependents

☐ Lifetime Benefit $__________ per Employee Only
$__________ per Employee + 1 Dependent
$__________ per Employee + 2 or more Dependents

☐ Monthly Benefit $__________ per Employee Only
$__________ per Employee + 1 Dependent
$__________ per Employee + 2 or more Dependents

HRA Funding Made Available:

☐ Annual election available on first day of plan year
☐ Annual election to be allocated as follows: ______________________________

HRA Funding Roll-Over:

☐ Unused benefits do not roll-over at the end of plan year
☐ Unused benefits roll-over at the end of plan year to maximum amount of:
$__________ per Employee Only
$__________ per Employee + 1 Dependent
$__________ per Employee + 2 or more Dependents
☐ Other ______________________________

HRA Proration:

☐ Benefits are not prorated for enrollment outside of annual open enrollment
☐ Benefits are prorated for enrollment outside of annual open enrollment
Specific Proration ______________________________

HRA Individual/Family Amounts:

☐ Benefit funding shared by family members with no individual limit per year
☐ Benefit funding embedded and limited to $__________ per individual per year. Please note that HRA plans where funding is embedded may not offer a benefit debit card due to plan design complexity.

Other HRA Plan Funding Features:

SECTION 9: PLEASE COMPLETE ONLY FOR HRA PLANS INTEGRATED WITH GROUP INSURANCE

Insurance Carrier Name(s)			
Insurance Plan Type (ex. PPO, etc.)			
Insurance Plan Year Start Date		**Major Insurance Plan Accrual**	☐ Calendar Year
Insurance Plan Year End Date			☐ Plan Year
Insurance Family Deductible	☐ Embedded. Each family member has an individual deductible		
	☐ Aggregate. Full family deductible must be reached by an individual or by the family		
☐ **Please provide Marin Benefits with copies of all applicable Group Insurance Plan Summaries, SBCs and EOCs when available**			

IRS 213(d) Medical Expenses	
	☐ HRA plan includes coverage for all IRS 213(d) eligible expenses
	☐ HRA plan does not include coverage for all IRS 213(d) eligible expenses

Network Restrictions	
	☐ HRA plan reimburses In-Network charges only
	☐ HRA plan reimburses In-Network and Out-of-Network charges

Insurance Applicability	**HRA Eligible Expense**	**HRA Ineligible Expense**
Deductible	☐	☐
Copayments	☐	☐
Coinsurance	☐	☐

Medical Services	**HRA Eligible Expense**	**HRA Ineligible Expense**
Prescription Drugs	☐	☐
Durable Medical Equipment (DME)	☐	☐
Chiropractic	☐	☐
Acupuncture	☐	☐
Fertility	☐	☐
Other	☐	☐
Other	☐	☐

Please Describe HRA Plan Design and Eligible/Excluded Services:

SECTION 10: BROKER INFORMATION

Broker Agency		Broker Name		
Broker License #		Broker Phone		
Broker Email		Broker Fax		
Broker Street Address		Broker City	Broker State	Broker Zip

SECTION 11: ADMINISTRATIVE FEES

Estimated Total Number of Employees		Estimated Number of HRA Plan Enrollees*	
Monthly Administrative Fee Per Employee*		Initial Plan Setup Fee	
Monthly Flat Rate Plan Administrative Fee		Annual Renewal Fee	
Monthly Minimum Administrative Fee		Debit Card Issuance Fee	

**Marin Benefits' proposed rates are subject to change based upon actual HRA plan enrollment counts.*

I hereby authorize Marin Benefits Administrators to provide reimbursement account services based on the information provided in this application.

____

Authorized Signature

____

Print Name

____

Title

____

Date