

ADMIN AMERICA HRA SIMPLE PLAN APPLICATION

Agent Name: _____

Phone No: _____

Employer's Legal Name: _____

Mailing Address: _____

City, State, Zip: _____

Physical Address: _____

Employer Entity: Corporation S-Corporation LLC
 Partnership LLP Other: _____

Plan Name: _____
Health Reimbursement Arrangement (HRA)

Conditions of Eligibility: (choose one)

- Date of Enrollment in the Employer's Group Health Plan
 Date of hire (*i.e., no service required*).
 _____ days / months after date of hire. (circle applicable term)

Entry Date: (choose one)

- First day of the Plan Year / Month / Pay Period following eligibility
(circle applicable term)
 The same day as the conditions of eligibility are met

Per Plan Year Per Participant HRA Benefit

- Can HRA reimburse for eligible expenses of spouse and dependents covered under the Health Plan? Yes No
 HRA Benefits Based On Group Health Coverage Tier
Employee Only Coverage \$ _____
Employee + Spouse Coverage \$ _____
Employee + Child(ren) Coverage \$ _____
Family Coverage \$ _____

HRA Benefits:

- Deductible under the group health insurance plan: \$ _____
EE Deductible Responsibility after HRA: \$ _____
Who pays the first share of the deductible?
 Employee Employer / HRA
 Does HRA reimburse for Out of Network benefits? Yes No

Phone: (____) _____

Fax: (____) _____

Contact Person: _____

Email: _____

Employer Tax ID Number: _____

New Plan Amended Plan

Plan Number: 501 502 503 504 Other _____

Original Effective Date: _____

Amended Effective: _____

First Plan Year: From _____ to _____

(Future Plan Years must be 12 months beginning with the day after the previous Plan Year ends)

Total Number of Active Employees: _____

Total Number of Eligible Employees: _____

Administration Options

- Self Administered \$1,000.00 Set Up Fee
 Administered by Admin America
\$750.00 Set Up Fee

Reimbursement Mechanism:
(consult fee schedule)

- Client's Checks with / without digital signatures imprinted on the checks
(circle the applicable term)
 Admin America claims account checks
 Reimbursements paid through client's payroll

Group Health Insurance Carrier: _____

Plan Type and Number: _____

Comments: _____

Prepared and Authorized By: _____

Printed Name

Signature

Title

Date

Please submit this application along with:

- 1) Check for the Plan Set Up Fee (See Administrative Options Above)
- 2) Employee census (only for groups to be administered by Admin America)
- 3) Summary of the group health insurance plan benefits

Mail to: Admin America, attn: Georgia Andros, P.O. Box 1810, Roswell, GA 30077

	Employee Social Security or Other ID Number	Employee Last Name	Employee First Name	Coverage Tier (Employee Only, Family, etc.)	Coverage Type (HMO, PPO, etc)	Street Address	City	State	Zip Code
1									
2									
3									
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Plan Sponsor