Employer Reimbursement Account Application

Thank you for choosing HealthEquity as the administrator for your organization's reimbursement account(s). We look forward to working with you and your employees with your tax-advantaged plan(s).

Company Profile

Company Name:			Tax ID:		
Address 1:					
Address 2:					
City:		State:		ZIP:	
Phone:		Fax:			
Employer Entity (check one):	☐ C Corporation ☐ S Corporation ☐ Sole Proprietorship ☐ Limited Liability ☐ Government or Church				
Insurance Carrier:	Asuris Northwest Health				
	Deductible: Individual $_____________ Family: $_____________		OOP: Individual $_____________ Family: $_____________		

Group Profile

☐ Same as above

Company Name:			Tax ID:		
Address 1:					
Address 2:					
City:		State:		ZIP:	
Phone:		Fax:			

Contact Name 1:		Contact Name 2:	
Email:		Email 2:	
Phone:		Phone:	
Fax:		Fax:	
Financial Contact Name:			
Financial Contact Email:			

Effective Date:		Renewal Date:	

Division 1 Name:	
Division 2 Name:	
Division 3 Name:	

Payroll Calendar

Select the payroll frequency for the group.

☐ Weekly	Every _____ weeks on:	☐ Monday ☐ Tuesday ☐ Wednesday	☐ Thursday ☐ Friday
☐ Semi-monthly	☐ Day _____ and Day _____ of every month. ☐ The 1st 2nd 3rd 4th Last *(circle one)*	☐ Monday ☐ Tuesday ☐ Wednesday	☐ Thursday ☐ Friday
	and the 1st 2nd 3rd 4th Last *(circle one)*	☐ Monday ☐ Tuesday ☐ Wednesday	☐ Thursday ☐ Friday
☐ Monthly	☐ Day _____ of every _____ month(s). ☐ The 1st 2nd 3rd 4th Last *(circle one)*	☐ Monday ☐ Tuesday ☐ Wednesday	☐ Thursday ☐ Friday
Date of the first payroll:			

Payroll/Deposit Schedule

Select freqency in which payroll/deposit data will be provided to HealthEquity, **or**

☐ Payroll/deposit information will not be sent to HealthEquity. Instead, HealthEquity will assume deposits according to the payroll calendar.

☐ Weekly	Every _____ weeks on:	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	
☐ Semi-monthly	☐ Day _____ and Day _____ of every month. ☐ The 1st 2nd 3rd 4th Last (circle one)	☐ Monday ☐ Tuesday ☐ Wednesday	☐ Thursday ☐ Friday
	and the 1st 2nd 3rd 4th Last (circle one)	☐ Monday ☐ Tuesday ☐ Wednesday	☐ Thursday ☐ Friday
☐ Monthly	☐ Day _____ of every _____ month(s). ☐ The 1st 2nd 3rd 4th Last (circle one)	☐ Monday ☐ Tuesday ☐ Wednesday	☐ Thursday ☐ Friday
Date that the first file will be sent to HealthEquity:			

Eligibility			
Employees are eligible after ______ days from their hire date.			
Termination Rules:	☐ Days allowed for claim submission after termination ______.		
	☐ Days allowed to incur claims after termination ______.		
Open Enrollment Start Date:		End Date:	

Flexible Spending Account Plan Definition			
Plan Name:			
Plan Year Start Date:		Plan Year Date:	
Plan Type:	☐ Medical Flexible Spending Account		
	☐ Limited Purpose Flexible Spending Account		
Plan Start Date:		Plan End Date:	
Run Out Days:		Grace Period Days:	
Election Minimum:		Election Maximum:	
Plan Name:			
Plan Type:	☐ Dependent Care		
Election Minimum:		Election Maximum:	

Health Reimbursement Arrangement Plan Definition		
Plan Name:		
Plan Year Start Date:		Plan Year End Date:
Is this a short plan year?	☐ Yes ☐ No	
Section I		
Plan Type:	☐ Full Medical HRA	
	☐ Restricted HRA *(must complete section III)*	
Section II		
Employer Contributions:	Employee Only $______________ Employee + Spouse $______________ Employee + Child $______________	Employee + Children $______________ Family: $______________
Section III		
HRA Restrictions:	☐ Medical Deductible Indicate how the HRA will cover deductible expenses: ☐ HRA will reimburse first dollar up to the annual election amount. ☐ The HRA Deductible must be met before the HRA will begin to pay. HRA Deductible: Individual $______________ Family: $______________	
	☐ Medical Coinsurance	
	☐ Medical Copayments	
	☐ Pharmacy	
Section IV		
HRA Rollover Options:	☐ $ ______________may roll over to the next coverage period with a maximum accumulation of $______________. ☐ _______% of unused funds may roll over to the next coverage period with a maximum accumulation of $______________. ☐ HRA funds do not rollover.	
Section V		
Prorating of Mid-year Changes:	☐ Status change from High to Low (keep all) ☐ Status change from Low to High (get high) ☐ Do not prorate Mid Year Elections	

Multiple Account Hierarchy

If your group will be offering multiple plans, please indicate the order in which each plan will pay:

(number each plan. A 1 pays first, a 2 pays second) __________ HRA

__________ FSA

Debit Card

Will a debit card be offered to your participants? ☐ Yes ☐ No

If yes, please indicate which plans the debit card will be access:

☐ Medical Flexible Spending Account
☐ Limited Purpose Flexible Spending Account
☐ HRA

To assist with the number of debit card transactions that are substantiated at the point of sale, list all copayment amounts associated with the health plan coverage:

$ ______________ $ ______________
$ ______________ $ ______________
$ ______________ $ ______________

Non-Discrimination Testing:

Will you need discrimination testing performed for your plans? ☐ Yes ☐ No

If yes, you will need to provide HealthEquity additional eligibility information for each of your participants (ownership %, officer status, compensation, etc.). HealthEquity will provide additional instruction at the time of enrollment.

Employer Funding

Indicate the frequency in which HealthEquity will pull from your bank account to replenish the reserve account. The frequency will determine the reserve percentage.

	% of annual plan liability
☐ Daily	3%
☐ Weekly	7%
☐ Monthly	10%

Banking Information

The following banking information will be used for the initial funding and replenishing the reserve account

Please include a copy of a voided check to verify this banking information.

Bank Name: ____
Bank Address: ____
Bank Phone Number: ____
Routing Number: ____
Account Number: ____
Type of Account: ____

Person Authorizing: ____
Signature: ____
Phone Number: ____

Fees

Below are the employer fees associated with the administration of your HealthEquity Reimbursement Account(s). HealthEquity bills employers for fees on a monthly basis.

	1-500 Participants	501-3,000 Participants	3,000 + Participants
New Plan Setup (one-time fee per plan)	$250.00	$500.00	Negotiable
Monthly Administration Fee	$3.95 PAPM	$3.95 PAPM	$3.95 PAPM
2nd Account Monthly Administration Fee	$2.95 PAPM	$2.95 PAPM	$2.95 PAPM
Annual Renewal Fee	$250	$500	Negotiable
Mid-year Plan Admendment Fee	$250.00	$250.00	$250.00

PAPM stands for per account per month

Below are the employee fees associated with the administration of your HealthEquity Reimbursement Account(s). Fees will be credited against the employee's plan balance.

Debit Card	First 2 cards are free, $5.00 for each additional
Stop Payment Fee	$20.00 per transaction

Comments

Please include any other details regarding your plan(s) that were not captured above:

Signature

I hereby authorize HealthEquity to provide reimbursement account services based on the information provided in this Employer Application.

Signature: ______________________________

Name: ______________________________

Date: ______________________________

Please send the completed application to:

HealthEquity
15 W Scenic Pointe Drive, Suite 400
Draper, UT 84020

Fax: 801-999-7829

For assistance in completing this application, contact HealthEquity at 866-382-3510.