



Regence

Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association



HealthEquity™

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):	<input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Limited Liability <input type="checkbox"/> Government or Church		
Insurance Carrier:			
	Deductible: Individual \$ _____	OOP: Individual \$ _____	
	Family: \$ _____	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:	
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Division 1 Name:	
Division 2 Name:	
Division 3 Name:	

Payroll Calendar

Select the payroll frequency for the group.

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

Payroll/Deposit Schedule

Select frequency 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.

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

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
<input type="checkbox"/> Daily		3%
<input type="checkbox"/> Weekly		7%
<input type="checkbox"/> 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 \$20.00 per transaction
Stop Payment Fee	

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.