STERLING HEALTH SERVICES ADMINISTRATION
EMPLOYER APPLICATION
HEALTH REIMBURSEMENT ARRANGEMENT

EMPLOYER INFORMATION

Company Name:______________________________ Phone: (____) ______________

Street: ______________________________ Fax: (____) ______________

City: ______________________ State: ______________ Zip: ______________

Employer's Taxpayer Identification Number: ______________________________

Contact Name: ______________________ Title: ______________________

Contact Phone: (____) ______________ Contact E-mail:______________________

The following affiliated employers will adopt this Health Reimbursement Arrangement as Participating Employers (if there is more than one, or if Affiliated Employers adopt this after the date the Adoption Agreement is executed, attach a list to this Adoption Agreement of such Affiliated Employers including their names, addresses and taxpayer identification numbers):

☐ N/A
☐ Name of Affiliated Employer (s):

____

Is this a controlled group (company owned by another company)?

☐ Yes
☐ No

Type of Entity

☐ Corporation (including Tax-exempt or Non-Profit)
☐ S Corporation
☐ Limited Liability Company that is taxed as:
  ☐ A partnership or sole proprietorship
  ☐ A Corporation
  ☐ An S Corporation
  ☐ Sole Proprietorship or Non-Profit
  ☐ Corporation Partnership (including
  ☐ Limited Liability) Governmental Entity
☐ Other: ______________________________

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Health Reimbursement Arrangement.

PLAN SETUP INFORMATION/ARRANGEMENT OPTION

Effective Date ______________________________

☐ New HRA
☐ Renewal HRA
☐ Other: ______________________________

Plan Year Dates ______________ to ______________

NOTE: Most HRA plans are established based on your medical plan deductibles, which normally accumulate on a calendar year basis, therefore, there may be a short plan the first year to allow for this.

Number of Full time Employees: ___________

Frequency of amount postings

☐ Entire amount at the beginning of the Plan Year
☐ Quarterly (1/4 on the first day of each month of each quarter)

Sterling HRA Plan – This HRA will reimburse (Check One):

☐ **BASIC** – Medical Deductible Only
☐ **COMPREHENSIVE -** (all expenses under Sec.213(d)

A claim may be submitted up to ______days after:

The end of the Coverage Period
The end of each calendar year
Other: ______________________________

Contributions for New Hires after the start of the Plan Year:

☐ Will equal existing employees ☐ Will be prorated

ADMINISTRATIVE OPTIONS

COBRA Administration

☐ I would like Sterling Health Services Administration to administer the HRA funds for terminated employees.
☐ I prefer to administer the COBRA as it applies to our HRA plan.

Nondiscrimination Testing

☐ I would like Sterling Health Services Administration to conduct nondiscrimination testing as it applies to our HRA plan. I understand that I will have to provide additional reports to Sterling Health Services Administration if I select this option. If my plan is found to be discriminatory, I understand that I will need to make the necessary adjustments to the elections to ensure that the plan becomes non-discriminatory.
☐ I prefer to conduct the discrimination testing as it applies to our HRA plan.

ELIGIBILITY REQUIREMENTS

Open Enrollment Period ___________________________

Conditions of Eligibility

☐ No exclusions
☐ All employees who customarily work, excluding overtime, at least _____hours per week/year.
☐ Other: ____

Any Eligible Employee will be eligible to participate in the Health Reimbursement Arrangement upon satisfaction of the following:

☐ Date of Hire (no service required)
☐ _____years after date of hire
☐ _____months after date of hire
☐ _____ days after date of hire
☐ Other: ________________________________

Effective Date of Participation

An Eligible Employee who has satisfied the eligibility requirements will become a Participant on:

☐ The day on which such requirements are satisfied.
☐ The first day of the month following the date on which such requirements are satisfied.

Retirees or other terminated employees shall:

☐ Shall continue to be eligible for reimbursement of any remaining balances.
☐ May not participate and any unused amounts are forfeited at the end of the Plan Year.

HRA GROUP ENROLLMENT PLAN OPTIONS

Coverage Tiers & Annual Funding Amount (Please check all that apply and note the funding amount)

Choose the coverage tiers the employer wants to set up in the HRA plan by checking all of the boxes below that apply. Next to each coverage tier selected, write in the amount of annual funding you will make for that tier:

☐ Single: $________________
☐ Employee & Spouse: $_________________
☐ Employee & Child(ren): $ ______________
☐ Family: $ ______________

When will employer reimburse for claims?

☐ After employee pays the first $ _____________
☐ Employer pays first up to the limits described above
☐ Percentage share up to employer limits: ____________ % employee ___________ % employer

HRA FUND ROLLOVER

Will Employer Allow HRA Balance to Roll Over? Mark the correct box below:
☐ Yes
☐ No

If rollover of funds is allowed, please specify how much will rollover by checking the appropriate box below, including the dollar amount for partial rollovers:

☐ All remaining funds

☐ Remaining funds up to $ ___________________

HRA DEBIT CARDS

Employers can choose to order debit cards for their employees. Please check the appropriate box below, if you want employees to have the convenience of a HRA debit card to access funds in their HRA account. If you do not want cards ordered, please check "no":

☐ Yes, please order HRA debit cards for the employees in my HRA plan. I understand that one card will be sent automatically when the account is set up and that additional cards can be ordered for dependents who are covered under the plan. I understand that for each participant the first 2 cards are free. Additional cards can be ordered for $10 each. Replacement for lost or stolen cards is $10 each.

☐ No, I do not want to order debit cards for my employees covered under my HRA plan.

EMPLOYER FEES PAID TO STERLING

Sterling HSA Sales Representative complete the following information regarding employer fees paid to Sterling based on the HRA plan selected and associated pricing. Note that there is a minimum monthly fee of $50.

HRA plan one-time set-up fee: $______________

HRA monthly fee per participant: $______________

HRA plan annual renewal fee: $ ______________

APPLICATION AGREEMENT/SIGNATURE

We, the undersigned employer, affirm the accuracy of this application and acknowledge that this application can be relied upon for the preparation of the Health Reimbursement Arrangement with Sterling Health Services Administration and may be used in preparation of the Summary Plan Description and/or Plan Document. We also agree to indemnify Sterling Health Services Administration and hold Sterling Health Services Administration harmless against any and all loss, damage or lawsuits brought against Sterling Health Services Administration to recover benefits under the plan, unless such actions arise out of the willful act or negligence of Sterling Health Services Administration.

Dated this _____day of __________________, 20_________

Employer: ____

By: ____

Title: ____

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