CONSOCIATE HEALTH

HRA Implementation Checklist

Section 105 or HRA Implementation Checklist

To ensure a smooth and efficient transition to Consociate, we ask that you fill out the requested information below and fax to 217-233-2281. Consociate strives to provide exemplary service to our clients, and we look forward to working with you and your employees.

Effective Date: _____ Check Format: _____ EMPL _____ FAML _____ OUTP _____

General Information

Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

Benefits Coordinator Information

Name: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

Company Federal Tax ID Number: _____

Fiscal Year for Section 105 or HRA is: _____

Will we be processing claims for a prior plan year? ○ Yes ○ No

(If yes, we will need a copy of the company statement from the previous administrator)

Section 105/ HRA Information

○ Copy of Section 105/HRA Plan Document

○ Copy of Enrollment/Application Forms

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Plan Information

HRA will reimburse which of the following items:

○ Deductible ○ OOP (coinsurance) ○ Prescriptions ○ Copays ○ OTC items ○ Vision ○ Dental

Is the plan an open HRA (ie: covers all section 2130 expenses) ○ Yes ○ No

Insurance Carrier: _____

Plan Deductible/Employee _____ Plan Deductible/Family: _____

How is the deductible met? Individual: _____ Accumulative: _____

Employee Deductible Responsibility: First: _____ or Last: _____

Employer Deductible Responsibility: First: _____ or Last: _____

Employee OOP Responsibility: First: _____ or Last: _____

Employer OOP Responsibility: First: _____ or Last: _____

Will Employer Reimburse any Out of Pocket? ○ Yes (Amount and Conditions of Reimbursement) ○ No

Will the Benny card be used? ○ Yes (complete set-up and ACH Debit/Credit form) ○ No

Are Retirees included in the plan? ○ Yes ○ No

Is carryover deductible allowed? ○ Yes (Please provide report with totals) ○ No

How is Consociate receiving claims: ○ Manual ○ Electronic

Will unused funds rollover from one plan year to the next? ○ Yes ○ No

Is Consociate creating a new SPD for the Section 105/HRA?

○ Yes (Please complete the attached SPD questionnaire) ○ No (Please submit a copy of your current SPD)

Billing: ○ Flat Fee $_____ or ○ PEPM $_____

Set-up Fee Amount: $_____

Banking Information for Section 105/HRA

Would you prefer to utilize:

○ An account set up by Consociate on behalf of your organization at our banking partner

○ Your own account (A new bank account must be set up in order for Consociate to process claims)

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Please provide the following information:

Bank Name: _____

Bank Address: _____

Routing Number: _____

Account Number: _____

Starting Check Number: _____

○ Copy of voided check or deposit slip

Would you prefer the signature on the claims checks to be a representative from your organization?

○ Yes (Please complete the signature collection form)

○ No, the president of Consociate will be the signer

Banking Information for Section 105/HRA (continued)

Who will be the primary contact for approving and releasing the checks?

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Will the check register be Automatic Release ○ Yes ○ No

Check runs: ○ Daily ○ Weekly

Information Needed from Client

○ Copy of Section 105/HRA Plan Document

○ Copy of SPD Questionnaire

○ Copy of Enrollment

○ Signature Collection Form

○ Copy of Voided Check

○ Copy of Carryover Deduction Report

Official Use Only

Signature: _____ Date: _____