AMERICAN BENEFITS GROUP

# INDIVIDUAL COVERAGE HRA (ICHRA) - CLIENT INFORMATION FORM

## Company Profile

Legal Name of Organization: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Executive Officer (signer): _____

Title: _____ Email Address: _____

Telephone:_____ Business Activity: _____

Employer Fed Tax ID#: _____ Tax Year Start Date: _____

Date of Organization: _____ State of Organization: _____

Affiliated Employers *(list):* _____

_____ ☐ None

Organization Type *(please check)*:

☐ Non-Profit Organization ☐ Government Agency

☐ Partnership* ☐ Sole Proprietorship* ☐ LLC *(Limited Liability Company)**

☐ Sub-chapter "C" Corporation ☐ Sub-chapter "S" Corporation* ☐ Other _____

## POP

**You will need a Premium Only Plan (POP).** If you currently have a POP it will need to be amended to allow for individual Premium Reimbursements through the plan.

ABG can create your POP if needed. Please complete and submit our POP form linked here https://www.amben.com/demos/ClientInfoForms/Client_Info_Form_POP.pdf

_____ _____ _____

Form Submittal by Printed Name | Form Submittal by Signature | Form Submitted Date

We _____ are requesting American Benefits Group to administer an ICHRA (Individual Coverage HRA) for our employees, or class(es) of employees. We understand that in order to be treated as a tax preferred benefit this account is subject to regulations established by the IRS, DHHS and the DOL (84 FR 28888) effective 8/19/2019.

This HRA can only be offered to a qualifying class of our employees who are not covered by your group health plan.

We understand that we must provide employees who are to receive this ICHRA coverage, with the required ICHRA notice 90 days prior to the first day of the plan year, but that for plan years starting within the first 6 months of 2020, there is a safe harbor that will be met for these purposes as long as the notice is provided to your employees prior to the first day of the plan Year.

Our employees must provide ABG with documentation showing they are enrolled in an individual health plan and show the cost of the monthly premium for this plan, they must also sign an attestation along with the claim for their monthly premiums stating that they are covered and will retain this coverage throughout the plan year.

## Important Information about the ICHRA

**Are you currently offering a group health plan?** ☐ Yes ☐ No

**If No.** You are not required to meet the minimum class sizes

**If Yes**. Please see the class size requirements below

**Note you must meet the required minimum class sizes:**

| Size of Employer | Class Size Minimum |
|---|---|
| Less than 100 employees | 10 |
| 100-200 employees | 10% of employees rounded to nearest whole # |
| 22 + employees | 20 |

From the available list of classes below, please select the class of employees to whom you wish to offer an ICHRA and confirm that any member of a class selected are NOT eligible for your group health plan

- ☐ Full-time
- ☐ Part-time
- ☐ Employee located in a specific Geographic Region
- ☐ Seasonal Employees
- ☐ Collectively Bargained
- ☐ Within a 90 day waiting period
- ☐ Nonresident aliens with no US Based income
- ☐ Salaried
- ☐ Non-salaried
- ☐ Employees hired for temporary Placement
- ☐ Employees who are in combination of two or more the above classes i.e. full-time employees covered by a particular collective bargaining agreement

**Affordability**

How many Full-time employees or full-time equivalent employees do you have? _____

If you have 50 or fewer employees, you do not need to be concerned with meeting the affordability requirements of the ACA, however, if you have 50 or more full-time or FTEs then you will need to make sure that your ICHRA is "affordable" to avoid an penalties associated with the mandate.

(Affordability is determined based on the lowest cost silver plan and is a calculation of this cost minus 9.75* the employees household income)

**Safe Harbors for Affordability**

- Location – the calculation of the lowest cost silver plan can be based on the location of the employees' primary work address rather than home address
- Age Based Bands - providing rates that take into account employees' age—there is more information forthcoming on how this should be handled
- Prior Plan Year Rates – Use prior rates

## ICHRA Plan Design

**Funding**

The ICHRA funding must be distributed fairly to all employees who fall into a specific class, you may, however, differentiate on funding amounts based on age and family size.

**Plan Effective Date:** _____

Participation in the ICHRA (*please check*):

☐ As of date of hire

☐ From date of hire: ☐ 30 days ☐ 60 days ☐ 90 days

☐ First of the month following: ☐ DOH ☐ 30 days ☐ 60 days ☐ 90 days

☐ Other *(please explain)*: _____

**How are the funds in the HRA made available to your plan participants?**

☐ 100% at the beginning of the plan year

☐ Posted monthly on the first of each month

## ICHRA Plan Design (continued)

High Deductible Health Plan (HDHP) Compatable: ☐ Yes ☐ No

**Funding Amounts by Age Range:**

| **From: _____To: _____** | **From: _____To: _____** | **From: _____To: _____** | **From: _____To: _____** |
|---|---|---|---|
| Single: $_____ | Single: $_____ | Single: $_____ | Single: $_____ |
| 2 Person: $_____ | 2 Person: $_____ | 2 Person: $_____ | 2 Person: $_____ |
| Family: $_____ | Family: $_____ | Family: $_____ | Family: $_____ |

**Are the funds pro-rated?** ☐ Yes (upon date of entry) ☐ No

**Will funds carryover into the new Plan Year?** ☐ Yes ☐ No

**If Yes.** How much of the funds will carryover: ☐ 100% ☐ Other _____

AMERICAN BENEFITS GROUP

# REIMBURSEMENT ACCOUNTS FUNDING AGREEMENT

☐ New Account ☐ Change of Account Effective Date: _____

**American Benefits Group** does not hold Flexible Spending Account funds for our clients, and no payroll deductions should be sent to American Benefits Group. Our funding mechanism for the reimbursement of your plan participants' claims requires that you, the client, provide American Benefits Group with authorization to draft funds from your designated bank account. It is your responsibility to ensure that said account is funded adequately. By completing the form below you are authorizing American Benefits Group to draft funds from your designated bank account to reimburse your participants' claims. Please check and sign for each reimbursement method that you are authorizing: Direct Deposit; Check.

**IMPORTANT:** Please note that when the bank account is initially set up there will be a pre-authorization transaction of $1.00; this pre-authorization is a requirement to verify the account information. Debits will show as **M&I Bank**, **Med-I-Bank or MBI Benefits Inc** and the Company ID is **1383261866.**

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**Authorized Bank Account Information**

We _____ by signing next to the methods of reimbursement below, authorize American Benefits Group to reimburse claims by drafting funds from:

Bank Name _____

Routing #: ☐☐☐☐☐☐☐☐☐ Account #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please attach a VOIDED copy of the account holder's check.

**Reimbursement Methods:** As an employer sponsoring Reimbursement Accounts for your employees the following Reimbursement Methods are available to you:

☐ **Bank Draft Paired with Direct Deposit to Participant:**

Manual claims will be reimbursed once a week, the funds will be drafted from your authorized bank account and will be directly deposited to the participant's authorized bank account. These drafts will display on the employer's bank statement on Wednesdays labeled as American Benefits Group Claim Pmt with a company ID of **9165530001.**

By signing below you are confirming that your bank will allow transactions made by American Benefits Group with **ID: 9165530001** labeled as: Claim Pmt .

_____

Signature of Authorized Signer on Bank Account

_____

Printed Name

☐ **Check Reimbursements:**

In the event that all of your reimbursement account participants will not be providing Direct Deposit Authorization for manual claim reimbursements, you can agree to have American Benefits Group issue these reimbursements as checks. These checks will be issued from your authorized bank account using the signature of your authorized signer and available starting check numbers that you provide in section below. American Benefits Group provides the check stock needed for writing these checks, you may find a sample in the ***Administrator's Guide***. In the case that an employee loses or destroys a check, American Benefits Group will contact you, it is the Employer's responsibility to stop payments on lost or damaged employee checks. Once the check payment has been stopped, ABG will issue the employee a new check.

An image of the signature entered in the box to the right, will be printed on all checks issued pursuant to this agreement. Checks will be issued using the following starting check number . . .

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Signature of Authorized Signer on Bank Account

Printed Name

Either the Company or the Client may terminate this agreement at any time by a notice in writing, mailed to or delivered at the last known address of the other party, and that any payments due at the date of such termination, or thereafter falling due, shall be payable by the Client in accordance its obligations as Administrator under its Reimbursement Plan

## COBRA

Please note that Health Reimbursement Arrangements are governed by ERISA; HIPAA and COBRA regulations. With a COBRA qualifying event an HRA participant must be offered COBRA on their HRA benefit.

**What are the COBRA premium rates for your HRA?**

*Employee Only* _____ *Employee plus one* _____ *Family* _____ *Flat Rate* _____

☐ The COBRA premium rate is a bundled rate for both the Integrated Health Plan and the HRA.

☐ There will be separate premium for the Group medical plan and the integrated

## Nondiscrimination Testing

In order to qualify for tax-favored status, self-insured medical plans must not discriminate in favor of highly compensated employees (HCEs) and key employees with respect to eligibility, contributions, and benefits. In order to evidence compliance, annual tests must be performed and the results documented for each benefit plan.

Under the 2007 proposed regulations, Code Section 105h nondiscrimination tests are to be performed as of the last day of the plan year, taking into account all non-excludable employees who were employed on any day during the plan year.

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**Per your Admin Agreement:**

**Testing Fees for Non-Assisted Testing run by client or broker through our NDX Testing Portal:**

First two NDX test sets per Plan Year ..... **Waived**

Additional NDX test sets per Plan Year ..... $395

**Testing Fees for Assisted Testing run by ABG:**

Per NDX test set ..... $495

**To perform the required tests** please complete the **Nondiscrimination Testing Request Form** linked here https://www.amben.com/demos/NondiscriminationTesting/ABG_NondiscriminationTestingRequestForm.pdf