UnitedHealthcare
A UnitedHealth Group Company

HRA Benefit Form

Please document your demographic information and HRA selections below, and then proceed to Sections 2 and 3.

SECTION 1: EMPLOYER INFORMATION AND HRA SELECTIONS

Client Demographic Information		
Business Name	Address	
City	State	
Zip	Effective Date of Policy	
Policy Number (if available)		
Employer HRA Benefit Contact Information: Who is the contact for HRA funding and benefits?		
Name (First, MI, Last)	Phone Number	
Address 1	Fax Number*	
Address 2	Email Address*	
City	State	Zip
*At least one of these fields is required. This is how we will notify you of upcoming HRA withdrawals from the bank account you list below.		
Individual Annual HRA Contribution Amount **(Note: If adding an HRA off-policy, the HRA contribution will be automatically prorated)**		
$ (Family HRA amounts are automatically calculated in proportion to your medical plan deductible)		
Banking Information (Voided check must be attached to this Form) **Note: If multiple HRAs are being offered, each HRA should have a unique corresponding bank account.**		
US Financial Institution/Bank Name:	ABA 9-digit Transit Number:	
Bank Telephone Number:	Bank Account #:	
Bank Address:		
Will unused HRA funds be carried over from one year to the next? **(Only applies when medical plan deductibles are greater than $1000)**		
☐ Not applicable; deductible is $1000 or less.	☐ No (default)	☐ Yes
Will mid-year enrollment additions, such as new hires, get the full HRA allocation, or a monthly prorated amount? **In making this decision, you may consider whether or not deductibles are prorated for mid-year hires.**		
☐ Monthly Proration (Default)	☐ Full HRA Amount	

SECTION 2: AUTOMATED CLEARINGHOUSE (ACH) DEBIT AUTHORIZATION

By signing this authorization form, I understand I am authorizing UnitedHealthcare to debit our bank account at the US financial institution indicated above for all Health Reimbursement Account ("HRA") self insured claim payments and minimum balance requirements. I understand and agree that this authorization will remain in effect for any future bank account(s) I designate to UnitedHealthcare for the purpose of funding HRA claims. We are solely responsible for providing funds for these benefits; UnitedHealthcare has no responsibility to fund such payments. We will ensure sufficient funds are in the bank account at all times to cover each call for funds and that the appropriate debit filtering is authorized with the bank. If the necessary funds are not on deposit in the bank account and/or an ACH reject or reversal is received, we understand the HRA may be terminated immediately. We understand we are liable for any expenses incurred for the failure to provide funds timely and in the amount requested, as well as any collection fees that may result.

I will promptly notify UnitedHealthcare of any change to the bank account at least 30 days in advance of any change and provide an updated, debit authorization form. We understand it may take up to 10 business days for the new information to update UnitedHealthcare's systems and begin debiting a new bank account. We will ensure the existing bank account has adequate funds on deposit until the new bank account is functional.

Authorization

I hereby authorize UnitedHealthcare to initiate automated clearinghouse (ACH) debits to the financial institution and bank account indicated above for the purpose of providing funds for HRA benefits. The US financial institution is authorized to debit our bank account and provide funds to UnitedHealthcare. This authority remains in full force and effect for the bank account listed here, as well as any revised bank account information I supply to UnitedHealthcare, until the account ceases to be debited upon termination of the HRA and all liability has been paid. I have also read and agree to the terms and conditions outlined above, and in the HRA self insured Administrative Services Agreement provided with this form. I am duly authorized to execute this debit authorization on behalf of the company named above.

Authorized Signature ______________________ Printed Name ______________________

Title ______________________ Telephone Number ______________________

Date ______________________

SECTION 3: ADDITIONAL TERMS AND CONDITIONS

Providing Funds for Benefits. We will maintain a non-interest bearing bank account for the payment of Program benefits. You acknowledge that the bank account may contain money from one or more other sponsors of self-insured health plans.

Bank Account. You will open and/or maintain a Health Reimbursement Account bank account at the Your bank for purposes of providing us a means to access your funds for payment of Program benefits and expenses.

Minimum Required Balance. We will determine the minimum balance you need to maintain with us to ensure funds are on hand to pay claims for Plan benefits. The balance you maintain will be used to fund claims when issued each week and will be replenished at the next call for funds.

Issuing and Providing Funds for Checks. The checks we write and issue to pay Program benefits under this Agreement will be written on one or more common accounts that are a part of the network of accounts maintained at our bank for our self-funded customers.

Calls for Funds. The withdrawals for Program benefits are funded by the balance you maintain with Us and is replenished weekly whenever claim payments have been made. You will ensure there are always sufficient funds in your designated bank account for us to withdraw. On Tuesday of each week claims are paid, you will receive a funding notification indicating the amount that will be withdrawn from your designated bank account the following business day. We will initiative the transfer via an Automated Clearing House transfer (ACH). This transfer will replenish the balance you are maintaining with Us.

Underfunding. If you do not provide the required amounts for the minimum required balance or for claim payments that have been made: (1) We will make one additional attempt to collect funds before we place claims on check write hold the 5th business day following when funds should have been provided and suspend any of our other services under this Agreement for the period of time you do not provide the required payments. (2) We will terminate this Agreement effective as of any date after thirty (30) calendar days if you do not provide the required payments. The notice provisions contained in Termination Events within the Administrative Services Agreement, do not apply to this breach. You will pay interest on the amount of underfunding at the standard rate that we charge to our self-funded customers for underfunding of claim payments.

Termination of Agreement. When this Agreement terminates, the method of providing funds for Program benefits remains in place for a limited period of time. This period will be reasonable, determined by us, and consistent with the period applied to our self-funded customers.

The terms and conditions contained in Exhibits A and B are hereby incorporated into this HRA Benefit form, and its terms and conditions, by reference. Copies of Exhibits A and B are available upon request through your broker or UnitedHealthcare Representative. Copies are also available to current UnitedHealthcare clients through Employer eServices.

Acknowledgement and Agreement

On behalf of the Employer listed above, I acknowledge that I have reviewed and agree to the terms and conditions contained in this HRA Benefit Form, as well as Exhibits A and B provided to me by my Broker or UnitedHealthcare Representative. I hereby approve the content and authorize use of the language at Exhibit B for use as the summary plan description for the HRA plan described in Exhibit A. I represent and warrant that I have the ability to bind the Employer listed above to the terms and conditions contained herein. I also acknowledge that the HRA cannot be implemented until my completed, signed HRA Benefit Form is received and processed by UnitedHealthcare.

Authorized Signature

Printed Name

Title

Telephone Number

Date

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