PBS
Professional Benefit Services, Inc.

Health Reimbursement Arrangement Setup

Employer Demographic Information					
Employer Name:					
Plan Information					
Plan Effective Date:		Plan Year Begins:		Plan Year Ends:	
1st Payroll Date:		Open Enrollment Dates:	to		
Payroll Frequency:	☐ Weekly(52)	☐ Weekly(26)	☐ Semi Monthly(24)	☐ Monthly(12)	
Plan Name:					

Plan Trustee(s):_____

Do you have other plans in place: ☐ Yes ☐ No

Eligibility			
Does plan eligibility match group health plan?	☐ Yes ☐ No		
Employee Hour Requirement (per week):		Employee Age Requirement: *Maximum of 21*	
Length of Service:	☐ None ☐ 1 Month ☐ 2 Months		
Date of Eligibility:	☐ 1st of the month or ☐ immediately following fulfillment of eligibility conditions		
Exclusions or Notes:			

Health Reimbursement Arrangement Provisions			
Benefit Limits	EE: EE/Sp: EE/Ch: EE/Family:		
Medical Benefits	**Covered Expenses:**		
Deductible:	☐ Yes ☐ No % Reimbursed: 0% Ded ind must meet:_____/EE _____/EESp_____/EECh _____/EEFamily Benefit Limits:_____/EE _____/EESp_____/EECh _____/EEFamily		
Copays:	☐ Yes ☐ No % Reimbursed: 0% Benefit Limits:_____/EE _____/EESp_____/EECh _____/EEFamily		
Rx:	☐ Yes ☐ No % Reimbursed: 0% Benefit Limits:_____/EE _____/EESp_____/EECh _____/EEFamily		
Qualified Medical Expenses:	☐ Yes ☐ No % Reimbursed: 0% Benefit Limits:_____/EE _____/EESp_____/EECh _____/EEFamily		
Other:	☐ Yes ☐ No % Reimbursed: 0% Benefit Limits:_____/EE _____/EESp_____/EECh _____/EEFamily Description:_____		
Dental Benefits	☐ Yes ☐ No % Reimbursed: 0% Benefit Limits:_____/EE _____/EESp_____/EECh _____/EEFamily		
Vision Benefits	☐ Yes ☐ No % Reimbursed: 0% Benefit Limits:_____/EE _____/EESp_____/EECh _____/EEFamily		
Offer Benefits Card?	☐ Yes ☐ No	**EOB Required?**	☐ Yes ☐ No
Employer Group Health Plan Coverage Required?	☐ Yes ☐ No		
Runout: (# of days to submit claims after plan year end, i.e. 90)		**Fund Carryover?** (unused funds roll over into next plan year)	☐ Yes ☐ No
Other Restrictions:			

Authorizing Initials: _____ Date:_____