

**TPA Systems Inc./Employer Flexible
Health Reimbursement Arrangement Questionnaire**

COMPANY INFORMATION

1. Name of adopting employer (Plan Sponsor):
- 2a. Plan Sponsor address line 1: 2b. Plan Sponsor address line 2:
3. Plan Sponsor city: 4. Plan Sponsor state: 5. Plan Sponsor zip:
6. Plan Sponsor phone AC/Number: 7. Plan Sponsor fax AC/Number:
8. Plan Sponsor EIN: 9. Plan Sponsor fiscal year end:
- 10a. Plan Sponsor entity type:
[] C Corporation [] S Corporation [] Non-profit [] Partnership [] Limited Liability Company
[] Limited Liability Partnership [] Sole Proprietorship [] Union [] Government agency [] Other
- 10c. If 10a is "Other", enter Plan Sponsor entity type:
11. State of organization: 12a. The Plan Sponsor is a member of an affiliated service group: [] Yes [] No
- 12b. If 12a is "Yes", list all members of the group (other than the Plan Sponsor): _____
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- 13a. The Plan Sponsor is a member of a controlled group: [] Yes [] No
- 13b. If 13a is "Yes", list all members of the group (other than the Plan Sponsor): _____
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Contact Information:

21. Contact name: 22. Contact title:
23. Contact salutation: 24. Contact phone:
25. Contact fax: 26. Contact email:

PLAN DATA

A. General

1. Plan Number: 501 3a. Original effective date of Plan:
- 3b. Is this a restatement of a previously-adopted plan? [] Yes [] No
- 3c. If A.3b is "Yes", effective date of Plan restatement:
- 4a. Plan Year End (Month Day): 4b. The Plan has a short plan year: [] Yes [] No
- 4ci. If A.4b is "Yes", enter the start date of the short Plan Year:
- 4cii. If A.4b is "Yes", enter the end date of the short Plan Year:
5. Is the Plan subject to ERISA? [x] Yes [] No 6. Enter date to place on cover of SPD:

ELIGIBILITY

B. Other Company Benefit Plan

- 1a. An Employee is eligible to participate in the Plan under the same terms and conditions as under the Company benefit plan specified in B.1b: [] Yes [] Yes - with limitations and modifications [] No
- 1b. If B.1a is not "No", enter name of other Company benefit plan:
- 1c. If B.1a is "Yes - with limitations and modifications", describe limitations and/or modifications:

BENEFITS

C. Health Reimbursement Account - Maximum Benefit

- 3b.i. Maximum reimbursement for single covered individual:
- 3b.ii. Maximum reimbursement for two covered individuals:
- 3b.iii. Maximum reimbursement for three or more covered individuals:

Special Instructions: _____

C. Health Reimbursement Account - Deductible

- 4a. Enter the Health Reimbursement Account deductible in any Plan Year for one Covered Person:
- 4b. Enter the Health Reimbursement Account deductible in any Plan Year for two Covered Persons:
- 4c. Enter the Health Reimbursement Account deductible in any Plan Year for more than two Covered Persons:

Special Instructions: _____

C. Health Reimbursement Account - Coinsurance

- 5. If C.1a is not "Schedule of expenses", once the HRA deductible is met (if any), indicate the level of coverage provided under the HRA until the annual amount under C.3 is met:

Special Instructions: _____

C. Coordination with Other Plans

- 8. Describe method to coordinate coverage in the Plan with a Health Care Reimbursement Account ("HCRA") in a Company-sponsored cafeteria plan for expenses that are reimbursable under both this Plan and the cafeteria plan:
 None HRA first Cafeteria plan first
- 9a. Describe method to coordinate coverage in the Plan with Health Savings Accounts
 None Permitted Coverage Post Deductible Coverage
 Both Permitted and Post Deductible Coverage Suspended HRA
- 9b. If C.9a is not "None", the limitations shall apply to:
 All Participants Only Participants eligible to participate in the HDHP Only Participants enrolled in the HDHP

PLAN OPERATIONS

D. Other Provisions

- 6a. Indicate whether the Plan is subject to COBRA: Yes No
- 6b. If the plan is subject to COBRA, enter the number of days within which a Participant must notify the Plan Administrator of certain qualifying events such as divorce or legal separation or a dependent child's losing coverage:
- 7. Indicate whether the Plan is subject to HIPAA privacy rules: Yes No
- 8. Indicate whether the Plan is subject to HIPAA portability rules: Yes No
- 9. Indicate whether the Plan is subject to FMLA: Yes No

CUSTOM LANGUAGE APPENDICES

E. Custom Language

2. Enter custom language that is to be added as an Addendum to the Adoption Agreement.

ADMINISTRATIVE ELECTIONS

J. Coordination with a Company sponsored health plan

10. Indicate whether the SPD should contain information about how the HRA coordinates with company sponsored health insurance:

No Deductible only Other information only Deductible and other information

11. Enter the Company health insurance plan deductible (do not enter the HRA deductible):

12. Enter information for the SPD about how this plan coordinates with a Company sponsored health insurance plan: _____

J. Joinder Agreement

20. For purposes of generating a Joinder Agreement, enter the names of all employers who have adopted the plan, other than the lead plan sponsor, separated by a semicolon: _____
