

General employer group information

Group name:

Group number: _____ Group EIN: _____

Group address: _____ City: _____ State: _____ Zip: _____

Is the employer subject to ERISA (Employee Retirement Income Security Act of 1974 - schools, churches and cities are usually not subject)? Yes NO

If yes, what is the ERISA plan number? _____

Contact for legal process (title only): _____

PriorityHRA effective date / /	PriorityHRA benefit plan year / /	PriorityHRA renewal month
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Sales representative: _____

Employer entity (select one)

NOTE: Self-employed individuals including partners in a partnership, sole proprietors, more than 2% shareholders in a subchapter S corporation and members in an LLC are not eligible for an HRA. Instead, they can participate in a Medical Reimbursement Arrangement (MRA), which doesn't have rollover and has a different plan document.

HRA	MRA	
<input type="checkbox"/> C Corporation	<input type="checkbox"/> S Corporation	<input type="checkbox"/> Limited Liability Corporation
<input type="checkbox"/> Government Entity (ERISA does not apply)	<input type="checkbox"/> Partnership	<input type="checkbox"/> Sole Proprietorship

HRA plan design(s)

Are all subgroups/classes offered the same HRA product? Yes No

If yes, proceed with the following plan design: Active/COBRA Early retiree Retiree

If no, list subgroup/class and plan design offering for each.

Subgroup(s) or other differentiator	Classes	HRA design

Important: Complete the HRA Reimbursement Schedule located in the Plan Document and Summary Plan Description available in the Agent Center at priorityhealth.com and attach to this application. The HRA Reimbursement Schedule will only need to be completed at renewal if there are changes.

Business associate agreement

Is there a signed Business Associate Agreement on file? Yes No - Contact your sales representative

Funding of HRA claims

All HRA reports are stored in the Filemart tool on the Employer Center at priorityhealth.com. Individuals assigned by the Employer Group may access these reports once they have created a username and password on the Employer Center at priorityhealth.com. PHI indicates all details of a claim and does contain Protected Health Information (PHI). No PHI indicateds what checks were written and to whom they were sent and does not contain PHI. Please list the designated individuals to receive Weekly Funding Reports and select the type of report they should receive

Name	User ID	
		<input type="checkbox"/> PHI <input type="checkbox"/> No PHI
		<input type="checkbox"/> PHI <input type="checkbox"/> No PHI
		<input type="checkbox"/> PHI <input type="checkbox"/> No PHI

Banking setup

Will subgroups require separate banking arrangements? Yes No

If yes, complete the banking setup information for each subgroup.

Contact for funding questions

Phone number
()

Fax number
()

E-mail address

Account options (select one)

Priority Health Managed Benefits (PHMB) General Account - Complete the section below (PHMB)

This funding arrangement allows the employer group to utilize a Priority Health bank account that has been established specifically to generate checks for HRA funding. Priority Health ACH transfers the needed funding from the employer's designated account into the general account. Priority Health maintains and reconciles this account.

A weekly Funding Report is sent to the group on Wednesdays via FileMart. Priority Health transfers funds by ACH from the group's account into the PHMB account on Friday. Checks are released directly to providers.

Please include and send to the Priority Health sales representative one of the following: a voided check, copy of a voided check, copy of a bank statement or a letter from the bank to verify account numbers.

Individual account - available for large groups only (50+ eligible contracts)

This option is an employer-maintained account. With this option, the employer group must maintain sufficient funds in the account to make sure that funds are available for Priority Health to cover the HRA funding. Priority Health releases checks directly to the providers for reimbursable claims expenses. An additional \$150 will be charged for laser signature on checks.

Option 1: Zero Balance Account — No approval required; checks released on the same business day as funding notification

Option 2: Assume Two Days — No approval required; checks released two business days after funding notification

Beginning check number: _____

Please include and send to the Priority Health sales representative:

- The Signature Collection Form (original hardcopy required) - contact sales representative for form
- Magnetic Ink Character Recognition (MICR) specification sheet produced by the bank
- One of the following: A voided check, copy of a voided check, copy of a statement or a letter from the employer group's bank to confirm bank and account numbers

PHMB General Account authorization to honor certain transactions

Name of financial institution		Branch	
Street address:	City	State	Zip
Bank account number:	Bank routing number:		
Contact name (at financial institution)		Contact's phone number ()	
This account has ACH positive pay: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>The undersigned hereby requests and authorizes you to pay and charge the bank account noted above (the "Account") for debit entries or checks drawn on National City and payable to Priority Health Managed Benefits, Inc. or National City; provided there are sufficient funds in the Account at the time of presentation. The undersigned further agrees that the bank's rights with respect to each such check or debit entry shall be the same as if it were a check or debit entry drawn on the bank and signed personally by the undersigned. So long as this authority shall remain in effect, the undersigned shall indemnify the bank against any claims for honoring any checks or debit entries authorized hereby. This authority shall remain in effect until revoked in writing by the undersigned.</p>			
Company name			
Group number	Subgroup		
Authorized signature			
Name and title		Date	