Pacific Benefits iFlex, Inc.
Innovative Consumer Driven Health Care Solutions

Phone: (800-800-2090) Fax to: (916) 363-2117

Confidential Information for HRA Documents

Proposed Plan Year: From ____________ to ____________
(Must Be a Twelve (12) Month Period Unless Other Arrangements Have Been Made)

1. **Exact Name of Company: (list all affiliated companies)**

   ____

   Mailing Address: ____
   (Also Street Address, if different)

   ____

   Phone No.: ______________ Fax No.: _______________ E-Mail:____________________________________

   Primary Contact: ____ Extension: __________

   Employer Benefits Coordinator and Title: ____

   Name and Title of Document Signer: ____

   Broker: __________________________ Agency: _________________________ Phone: ________________

2. **Federal I.D. Number:** __________________ **Date Organized:** ____________________

   Organization Type (Circle One):
   (Corp., Sub-S Corp., Partnership, Proprietorship, Non-Profit, Gov. Agency, LLC, Other)

   Business Activity Code (SIC #): ________________ **State of Origin:** ______________________________

   Nature of Business: ____

3. **Plan Information:** Circle Type of Payroll(s)
   Weekly (48), Weekly (52), Bi-wkly (26), Bi-Wkly (24), Semi-Monthly, (24) Monthly (date), other _____________

   3a. ***If linked to Medical Plan, then eligibility should be the same as your Medical Plan***

   Service Period Requirement (30, 60, 90 days, etc.): ____
   Initial Plan Year or All Plan Years: ____
   Entry Date (First of Month, First Pay Date, etc.): ____
   Hours per Week to Qualify For Benefits: _______________________ **Minimum Age** _________________
   Seasonal Employees Hours to Qualify: __________________________ **Union Employees Eligible (Y) (N)**

4. **Reimbursement Method:** Weekly Direct Deposit is **Default**,
   Checks to EE's homes _____ Debit Card, if available _____

5. **HRA Plan Design & Coverage:** Flat Amount per year at 100%: Employee __________; Family ___________

☐ Deductible for HRA ________________ ☐ Co-insurance Amount for HRA ____________, up to $ ____________
☐ Only amounts toward Deductible
☐ Amounts toward Deductible as well as specified Co-pays, ____
☐ 100% first dollar to $_________, then _________ co-insurance thereafter to $__________
Carryover Amount ___________

THE ABOVE INFORMATION IS BEING PROVIDED WITH THE INTENT OF ESTABLISHING A SECTION 105 PLAN WITH PACIFIC BENEFITS iFLEX, INC. BEING THE CONTRACT ADMINISTRATOR

____ ___________________
SIGNATURE AND TITLE DATE