



HRA Renewal Form

It's renewal time! The following information is required to renew your TASC HRA plan and **MUST BE RECEIVED 30 DAYS PRIOR** to your new plan year start.

| | | |
|--|--|---|
| Submit this completed form via one of the following methods: | Online Support Request | Mail |
| | Go to www.tasconline.com - Click LOG IN Sign into your Universal Benefit Account Create a Support Request and attach completed form | TASC PO Box 7308 Madison, WI 53707-7308 |

CLIENT/EMPLOYER INFORMATION

| | | | | | | |
|-------------------------------|-------------------|--|-------------------------|-------------------------------|---------------|--|
| Client/Employer Name: | | | TASC ID #: | | | |
| Division: | | | | | | |
| Client/Employer Email: | | | | Client/Employer Phone: | | |
| Primary Address: | Address 1: | | | | Suite: | |
| | Address 2: | | | | | |
| | City: | | | | | |
| | State: | | ZIP/Postal Code: | | +4 | |

PLAN INFORMATION

| | | | | | |
|------------------------------|--|----------------------------|-------------------|------------------------------|---------------|
| Plan Year Start Date: | | Plan Year End Date: | | Total Employee Count: | |
| Renew my HRA Plan: | <input type="checkbox"/> With NO changes <input type="checkbox"/> With the changes indicated below. Effective Date: If plan changes are required, please make selections and complete the required information below. | | | | |
| <input type="checkbox"/> | Change in TASC HRA Plan Eligible Benefits for Reimbursement: <i>(Example: Deductible, Coinsurance, Prescription, Copay, etc.)</i> | | | | |
| <input type="checkbox"/> | Change in TASC HRA Deductible: (The TASC HRA deductible is the amount for which a participant is responsible prior to any HRA reimbursement. If there is no HRA deductible, indicate \$0. <i>This is not the same as your health insurance deductible.</i>) | | | | |
| | Individual Maximum \$ | | Family Maximum \$ | | |
| <input type="checkbox"/> | Change in Plan Reimbursement Amounts: | | | | |
| | % | From \$ | To \$ | TASC/Employer Reimbursed \$ | |
| | % | From \$ | To \$ | TASC/Employer Reimbursed \$ | |
| | % | From \$ | To \$ | TASC/Employer Reimbursed \$ | |
| | % | From \$ | To \$ | TASC/Employer Reimbursed \$ | |
| | Maximum TASC/Employer reimbursement | | Per Individual \$ | | Per Family \$ |
| CONTINUED ON PAGE 2 | | | | | |



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| | | | |
|--|--------------------------|--|------------------------|
| <input type="checkbox"/> Change in Plan Reimbursement Design (Individual or Family): | | | |
| | <input type="checkbox"/> | Individual family member (maximum reimbursement capped at maximum amount per member) | |
| | <input type="checkbox"/> | Family aggregate (an individual of the plan or a combination of family members may receive reimbursement up to the maximum family amount elected or any combination of reimbursements) | |
| <input type="checkbox"/> Change in Medical Plan Insurance Carrier: | | | |
| | Current Carrier: | | New Carrier: |
| <input type="checkbox"/> Change in Debit Card Copay Substantiation (if applicable): | | | |
| | Medical Copay: | | Dental: |
| | Medical Copay: | | Vision, if applicable: |
| | Medical Copay: | | Prescription Copay: |
| | Medical Copay: | | Prescription Copay: |
| | Medical Copay: | | Prescription Copay: |
| <input type="checkbox"/> Change in availability of TASC HRA Plan Benefits for Reimbursement | | | |
| | <input type="checkbox"/> | Entire Annual Benefit is available as of first day of plan year | |
| | <input type="checkbox"/> | Annual Benefit is prorated on a monthly basis and available the first of each month | |
| NOTES: | | | |

| | | | |
|--------------------------------|--|-------|--|
| Completed By (Client Contact): | | Date: | |
|--------------------------------|--|-------|--|

For enrollment assistance: call toll-free 800-422-4661
Have your form, employer name, and the Client ID# ready.
 Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits/.