HRA Renewal Form

It's renewal time! The following information is required to renew your BASIC 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**	**Fax**	**Mail**
	Log onto your online account at https://cdaclient.basiconline.com/ and attach the completed form via Support Request	608-245-3623	BASIC, PO Box 7308 Madison, WI 53704-7308

CLIENT/EMPLOYER INFORMATION

Client/Employer Name:			Client/Employer ID #:		
Division: (If applicable)					
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: ☐ **With NO changes**

☐ **With the changes indicated below. Effective Date:**

If plan changes are required, please make selections and complete the required information below.

☐	**Change in HRA Plan Eligible Benefits for Reimbursement:** *(Example: Deductible, Coinsurance, Prescription, Copay, etc.)*						
☐	**Change in HRA Deductible:** (The HRA deductible is the amount for which a participant is responsible prior to any HRA reimbursement. If there is no HRA deductible, indicate $0. *This is not the same as your health insurance deductible*.)						
	Individual Maximum $		Family Maximum $				
☐	**Change in Plan Reimbursement Amounts:**						
	%	From $		To $		BASIC/Employer Reimbursed $	
	%	From $		To $		BASIC/Employer Reimbursed $	
	%	From $		To $		BASIC/Employer Reimbursed $	
	%	From $		To $		BASIC/Employer Reimbursed $	
	Maximum BASIC/Employer reimbursement		Per Individual $		Per Family $		

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☐	**Change in Plan Reimbursement Design (Individual or Family):**			
	☐	Individual family member (maximum reimbursement capped at maximum amount per member)		
	☐	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)		
☐	**Change in Medical Plan Insurance Carrier:**			
	Current Carrier:		New Carrier:	
☐	**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:	
☐	**Change in availability of BASIC HRA Plan Benefits for Reimbursement:**			
	☐	Entire Annual Benefit is available as of first day of plan year		
	☐	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 800-372-3539
Have your form, employer name, and the Client ID# ready.
Find all IRS limits on our resource web page: https://www.basiconline.com/hq/employer/basic_cda/