

Anthem Demand Debit Authorization (DDA) Form For Small Group Lumenos HRA Claims Reimbursement



Completed form must be submitted with your application.

We hereby authorize Anthem Blue Cross to initiate debit entries for HRA claims reimbursements or any other related payments on our behalf and credit entries as required to our account indicated below, and authorize the financial institution named below to debit/credit the same to such an account.

Enrollment type: <input type="checkbox"/> Initial <input type="checkbox"/> Revised		Requested effective date	
FINANCIAL INSTITUTION INFORMATION			
Group financial institution name			
Group financial institution street address		City	State ZIP code
Account no.		Bank ABA no.	
Account type: <input type="checkbox"/> Checking/Negotiable Order of Withdrawal (NOW) <input type="checkbox"/> Savings <input type="checkbox"/> Other If other, please specify: _____			
ACH Block on this account (Is an originator ID needed)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
GROUP INFORMATION			
Group name		E-mail address	
Group street address		City	State ZIP code
Group contact person		Phone no.	

Initial Group Enrollment – Required Deposit:

\$

Once the policy is active, the Required Deposit will be automatically withdrawn from your bank account. Thereafter, on a monthly basis, you will be notified of claims paid under the HRA account, and three business days later that amount will be withdrawn from your bank account.

Demand Debit Authorization Form is required for HRA claims reimbursement ONLY.
NOTE: Completion of a new DDA form is required when changes are made to your financial institution information.

By signing below the group acknowledges and agrees to abide by the terms of the Agreement for Health Reimbursement Accounts. This Demand Debit Authorization is to remain in full force and effect until Anthem or the above-named financial institution has received written notification from you of its termination in such time and in such manner as to afford Anthem and the above-named financial institution a reasonable opportunity to act on it. **Please note** that the termination of this demand debit authorization will terminate the agreement for health reimbursement accounts and terminate HRA claims reimbursement.

Printed name	Authorized signature on this account X	Date
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Submit the Demand Debit Authorization (DDA) Form with your HRA Agreement.
Please ensure any limits on your account are sufficient to cover the monthly invoice.

FOR INTERNAL USE ONLY		
Underwriter name	Group no.	Effective date
Comments		

WORKSHEET

To offer one or more Lumenos HRA plans to your employees, complete one section for each plan offered below. Calculate the estimated maximum HRA funding liability amount by multiplying the annual HRA contribution by the number of employees. Add the highlighted boxes for each plan and put the total in the **Sum of Total Estimated Maximum HRA Funding Liability** field. Multiply this amount by .10 (or 10%) to determine the **Initial Required Deposit** in the shaded box. Transfer this amount to the **Initial Group Enrollment – Required Deposit** field on page one. (Key: X means multiply, + means add)

Benefit Plan Option 1:	Employee Only	Employee+Spouse Employee+Child(ren) Family	Total
Number of employees:	<input type="text"/>	<input type="text"/>	
Annual HRA Contribution per employee: (Based on your Benefit Plan Option)	X <input type="text"/>	X <input type="text"/>	
Estimated Maximum HRA Funding Liability:	<input type="text"/>	+ <input type="text"/>	= <input type="text"/>

Benefit Plan Option 2:	Employee Only	Employee+Spouse Employee+Child(ren) Family	Total
Number of employees:	<input type="text"/>	<input type="text"/>	
Annual HRA Contribution per employee: (Based on your Benefit Plan Option)	X <input type="text"/>	X <input type="text"/>	
Estimated Maximum HRA Funding Liability:	<input type="text"/>	+ <input type="text"/>	= <input type="text"/>

Benefit Plan Option 3:	Employee Only	Employee+Spouse Employee+Child(ren) Family	Total
Number of employees:	<input type="text"/>	<input type="text"/>	
Annual HRA Contribution per employee: (Based on your Benefit Plan Option)	X <input type="text"/>	X <input type="text"/>	
Estimated Maximum HRA Funding Liability:	<input type="text"/>	+ <input type="text"/>	= <input type="text"/>

Benefit Plan Option 4:	Employee Only	Employee+Spouse Employee+Child(ren) Family	Total
Number of employees:	<input type="text"/>	<input type="text"/>	
Annual HRA Contribution per employee: (Based on your Benefit Plan Option)	X <input type="text"/>	X <input type="text"/>	
Estimated Maximum HRA Funding Liability:	<input type="text"/>	+ <input type="text"/>	= <input type="text"/>

Total of Benefit Plans 1-4:	Total
Sum of Total Estimated Maximum HRA Funding Liability from above benefit plans:	<input type="text"/>
Initial Required Deposit:	X .10 (10%) <input type="text"/>

Complete the information below. The HRA deductible allocation percent and rollover amount must be the same for each HRA plan.

HRA Arrangement	Rollover Amount
Annual Deductible Allocation _____% (up to 50%)	<input type="checkbox"/> 1 x the annual deductible allocation <input type="checkbox"/> 3 x the annual deductible allocation <input type="checkbox"/> 2 x the annual deductible allocation <input type="checkbox"/> Unlimited