Funding Account Renew As-Is Form

Use this form only if you are not making any changes to your company's health reimbursement arrangement (HRA), flexible spending account (FSA), or health savings account (HSA). To determine if changes are needed, refer to your current year's Administration Agreement, or speak with your broker or CDPHP® representative to check the details of your HRA and/or FSA plan design. If changes are being made, a new Administration Agreement must be completed.

Company Name: ____

CDPHP Group Number: ____

I am not making any changes to my company's health funding account plan administered through Capital District Physicians' Healthcare Network, Inc. (CDPHN). Please renew the HRA and/or FSA and/or HSA as is.

- **Check all that apply below, and complete any required information.**
- **You must also submit an Enrollment Roster and FSA Election Forms, if applicable.**
- **Important note: The CDPHN HRA/FSA Administration Agreement has been updated with a new Exhibit A, a copy of which is attached and will go into effect upon your anniversary date. By signing below, you are acknowledging and agreeing to the information you supply here and to the amended Exhibit A of the CDPHN HRA/FSA Administration Agreement.**

Funding Account Type	Renew As Is	Additional Details
HRA	○	○ Please confirm that you are not funding more than 50% of your medical plan deductible.*
Health FSA	○	Please complete the following payroll information for a health and/or dependent care FSA: First payroll date in plan year: ______________ Payroll frequency: ○ Weekly ○ Bi-Weekly ○ Monthly ○ Other: ________
Dependent Care FSA	○	
HSA	○	Log in to the employer portal with My BenefitWallet™ to make any necessary changes to your employee funding/contributions.

Name: ______________________________ Title: ______________

Signature: ______________________________ Date: ______________

**For small business plans only*