



AMERICAN BENEFITS GROUP

CLIENT INFORMATION FORM - FLEXIBLE SPENDING ACCOUNTS

Company Profile

Legal Name of Organization: _____ Broker of Record: _____
 Mailing Address: _____
 City: _____ State: _____ Zip: _____
 Executive Officer (signer): _____ Title: _____
 Email Address: _____ Telephone: _____
 Website URL: _____ Employer Fed Tax ID#: _____
 # of Years in Business: _____ Date Established: _____
 State of Incorporation: _____ # of Years at Location _____
 Affiliated Employers (list): _____

None

Organization Type (please check): Privately Owned Publicly Owned

Ownership Structure (please check): Principal Ownership Under 25% Principal Ownership Over 25%

Type of Incorporation (please check): Non-Profit Organization Government Agency
 Partnership* Sole Proprietorship* LLC (Limited Liability Company)*
 Sub-chapter "C" Corporation Sub-chapter "S" Corporation* Other _____

* **Note:** Subchapter S Corporation shareholders above the 2% level **may not** participate, but they may sponsor a plan for their employees. In addition, family members and close relatives of these shareholders **may not** participate. LLC, LLP and Sole Proprietors **may not** participate, but may sponsor a plan for their employees. However, if the spouse is a bona fide employee of the firm, he or she may participate and use the benefit for the entire family.

Type of Business (please check): Business to Business Business to Consumer
 N/A Government Agency N/A Non-Profit International Presence Yes

COBRA

Is ABG Administering your COBRA? Yes No

COBRA Administrator: _____

Mailing Address: _____

INSURANCE CARRIERS

Medical: _____

Dental: _____

Vision: _____

Form Submittal by Printed Name

Form Submittal by Signature

Form Submitted Date

Employer Plan Administrators

Administrator Access: ABG can provide a read-only access to our WealthCare Administration system for Employer Plan Administrators. Those being provided with access should either have been designated as a privacy officer, or have been cleared for access to Protected Health Information (PHI) per HIPAA requirements.

Scheduled Reports include information about account balances, debit card transactions and claim reimbursements. Scheduled reports in the system do not contain PHI or Personal Information (PI).

		Administrator Access?	Scheduled Reports?
Primary HR:	Title:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Tel:		
Payroll:	Title:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Tel:		
Billing/Finance:	Title:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Tel:		
Broker Contact:	Title:	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Tel:		

Nondiscrimination Testing

In order to qualify for tax-favored status, Cafeteria, Flexible Spending and Health Reimbursement benefit plans must not discriminate in favor of highly compensated employees (HCEs) and key employees with respect to eligibility, contributions, and benefits. In order to evidence compliance, annual tests must be performed and the results documented for each benefit plan.

Under the 2007 proposed regulations, Code Section 125 nondiscrimination tests are to be performed as of the last day of the plan year, taking into account all non-excludable employees who were employed on any day during the plan year. Some employers choose to perform these tests mid plan year in order to determine whether additional steps need to be taken before the end of the plan year so that the plan passes the nondiscrimination tests and preserves the tax treatment for the key and highly compensated. A second and final test would then be conducted as of the last day of the plan year.

Per your Admin Agreement:

Testing Fees for Non-Assisted Testing run by client or broker through our NDX Testing Portal:

First two NDX test sets per Plan Year **Waived**
 Additional NDX test sets per Plan Year \$395

Testing Fees for Assisted Testing run by ABG:

Per NDX test set \$495

To perform the required tests please complete the **Nondiscrimination Testing Request Form** linked here https://www.amben.com/demos/NondiscriminationTesting/ABG_NondiscriminationTestingRequestForm.pdf

IMPORTANT: If we do not receive the Nondiscrimination Testing Request Form, we will assume that you do not want to test your Plan(s) with ABG.

Flexible Spending Accounts

Enrollment

Open Enrollment Period: Start Date _____ End Date _____

Will you be using the **ABG Online Enrollment System**? Yes No

If No, you must submit employee profile and election to American Benefits Group in an Excel template *linked here* [Enrollment Submission Spreadsheet \(XLS\)](#)

What is your Current HRIS / Enrollment System (if any)? _____

Will you be submitting ongoing eligibility files? Yes No

Eligibility Guidelines

Number of Benefit Eligible Employees: _____

Participation in the Plan Begins (*please check*):

As of date of hire

From date of hire: 30 days 60 days 90 days Other _____

First of the month following: DOH 30 days 60 days 90 days Other _____

Other (*please explain*): _____

Eligible Classes of Employees Covered (*please check all that apply*):

Active _____ min. hours per week worked

Union

Other (*please explain*): _____

Do you track your employees by Division? If yes, please list them here: _____

Payroll Contributions (*please complete all applicable fields*)

Will you be submitting ongoing payroll files? Yes* No

If No, ABG will assume payroll contributions based on the frequency below.

FREQUENCY	PLAN START DATE	PLAN END DATE	FIRST PAYROLL DATE	LAST PAYROLL DATE	NO. OF PAYROLLS PER PLAN YEAR
Monthly					
Semi-Monthly					
Bi-Weekly					
Weekly					
Other					

Qualified Reservist Election

A special rule allows amounts in a health FSA to be distributed to reservists ordered or called to active duty. This rule applies to distributions made after June 17, 2008, if the plan has been amended to allow these distributions. Your employer must report the distribution as wages on your Form W-2 for the year in which the distribution is made. The distribution is subject to employment taxes and is included in your gross income.

A qualified reservist distribution is allowed if you were (because you were in the reserves) ordered or called to active duty for a period of more than 179 days or for an indefinite period, and the distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the plan year that includes the date of the order or call.

Have you adopted the *Qualified Reservist Election*? Yes No

Flexible Spending Accounts – Plan Design

Plan Effective Date: _____ Plan Name: _____

When did you first begin taking pre-tax deductions under a Section 125 Plan? _____

When did you first add FSA reimbursement accounts? _____

The name of the TPA that was previously administering the plan? _____

What is the 3 digit ERISA plan number associated with your Section 125 Plan? _____

If the Plan is a takeover, who will be responsible for processing run-out claims: Previous Administrator ABG

Check here if this is a short plan year: Start Date: _____ End Date _____

Check here if this is a mid-year takeover: Start Date: _____ Take-over Date: _____ End Date: _____

Simple Cafeteria Plans

The Affordable Care Act amended the Internal Revenue Code and added regulations for the Simple Cafeteria Plan. The major benefits of a Simple Cafeteria Plan are the ease of implementation, and the safe harbor granted from the nondiscrimination testing of the Internal Revenue Code. Simple Cafeteria Plans will be treated as meeting the nondiscrimination requirements.

The employer has met the requirements for being a simple cafeteria plan if these four basic requirements are satisfied:

- Employer size. The employer (including certain affiliated entities) must have employed an average of 100 or fewer employees in either of the two preceding years. Special rules apply to new employers and certain growing employers with fewer than 200 employees.
- Eligibility. In general, all employees with at least 1,000 hours of service during the preceding plan year (other than certain excludable employees) must be eligible to participate in the plan.
- Benefits. Each employee who is eligible to participate must be able to elect any qualified benefit (other than cash) available under the plan (subject to any terms and conditions that apply to all participants).
- Required employer contributions. Each employee who is not a key employee or highly compensated must receive a "true" employer contribution of at least: (1) two percent of the employee's compensation for the plan year, or (2) the lesser of six percent of the employee's compensation for the plan year or twice the employee's salary reductions.

Will you be offering a Simple Cafeteria Plan? Yes No [More information about Simple Cafeteria Plans](#)

Please check the benefits to be included under your Section 125 Cafeteria Plan (even those not administered by ABG):

Medical Dental and/or Vision Premium Conversion

Health Flexible Spending Account (FSA) Dependent Care Assistance Plan (DCAP)

Limited-purpose FSA (LPF) Health Savings Account

Other (please list) _____

Maximum FSA Election: _____ (if less than the IRS Maximum FSA) Minimum, if any: _____

Maximum LPF Election: _____ (if less than the IRS Maximum LPF) Minimum, if any: _____

Maximum DCAP Election: _____ (if less than \$5,000 the IRS Maximum DCAP) Minimum, if any: _____

Will Employer Contribute to the plan? Yes* No

*If Yes, please provide detail of contribution amounts and the timing of contributions:

Run-Out Period**Active Employees**

At the end of the plan year, how many days do you want active employees to have to submit claims for reimbursement incurred in the previous plan year? 3 months Other _____

Terminated Employees

Employee's FSA coverage ends on the day of their termination. How many days after their termination do employees have to submit claims for reimbursement incurred prior to termination? 90 days Other _____

Grace Period

(if you choose Grace for your Health FSA – you may not choose carryover)

A Grace Period is an optional extension of up to 2.5 months after the plan year ends to incur expenses against all remaining funds in the previous plan year.

Are you currently offering a Grace Period? Yes No

Do you want to offer employees a Grace Period? Yes* No

*If Yes, please indicate the last day claims may be incurred 2.5 months (maximum) Other _____

Apply Grace Period to Health FSA? Yes No

Apply Grace Period to DCAP? Yes No

Carryover Provision

(if you choose the Carryover – you may not choose the grace period for the Health FSA, however you may have the grace for the DCAP)

The optional Carryover Provision allows employees who make an election for the new plan year in the amount of \$100 (our recommendation), to rollover up to \$500 of unused Health FSA funds at the end of the plan year. The rollover of these funds will occur after the run-out period is complete. Carryover funds can be used for new plan year expenses.

Are you currently offering the Carryover Provision? Yes No

Do you want to adopt the Carryover Provision? Yes* No

*If Yes, please indicate the amount which can be carried over \$500 Other _____

Employees **must make an active new plan year election** to take advantage of the Carryover Provision.

New plan year election minimum: \$100 Other _____



AMERICAN BENEFITS GROUP

REIMBURSEMENT ACCOUNTS FUNDING AGREEMENT

New Account Change of Account Effective Date: _____

American Benefits Group does not hold Flexible Spending Account funds for our clients, and no payroll deductions should be sent to American Benefits Group. Our funding mechanism for the reimbursement of your plan participants' claims requires that you, the client, provide American Benefits Group and the debit card company MBI (M&I) Bank, with authorization to draft funds from your designated bank account. It is your responsibility to ensure that said account is funded adequately. By completing the form below you are authorizing American Benefits Group to draft funds from your designated bank account to reimburse your participants' claims. Please check and sign for each reimbursement method that you are authorizing: Debit Cards; Direct Deposit; Check. **If there are ACH failures you will be billed \$25 for each failure.**

IMPORTANT: Please note that when the bank account is initially set up there will be a pre-authorization transaction of \$1.00; this pre-authorization is a requirement to verify the account information and is non-refundable. Debits will show as **M&I Bank, Med-I-Bank or MBI Benefits Inc** and the Company ID is **1383261866**.

Authorized Bank Account Information

We _____ by signing next to the methods of reimbursement below, authorize American Benefits Group to reimburse claims by drafting funds from:

Bank Name _____

Routing #:

--	--	--	--	--	--	--	--	--	--

 Account #:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Please attach a VOIDED copy of the account holder's check.

Reimbursement Methods: As an employer sponsoring Reimbursement Accounts for your employees the following Reimbursement Methods are available to you:

- ABG Benefits Card Replenishments:**
Debit card transactions make funds available to your plan participants with the swipe of a card. The funds for these card swipes will be drafted from your designated employer bank account on a daily basis, a daily email will be sent to you advising you of this transaction.

Card will be available for the following FSA Plans:

- Health FSA DCAP Commuter Transit Commuter Parking

Card will be available for the following HRA Expenses:

- RX 213D expenses

By signing below you are confirming that your bank will allow transactions with **ID:1383261866** labeled as: M&I Bank or Med-I-Bank. **If there are ACH failures you will be billed \$25 for each failure.**

Signature of Authorized Signer on Bank Account

Printed Name

Bank Draft Paired with Direct Deposit to Participant:

Manual claims will be reimbursed once a week, the funds will be drafted from your authorized bank account and will be directly deposited to the participant's authorized bank account. These drafts will display on the employer's bank statement on Wednesdays labeled as American Benefits Group Claim Pmt with a company ID of **9165530001**.

By signing below you are confirming that your bank will allow transactions made by American Benefits Group with **ID: 9165530001** labeled as: Claim Pmt. **If there are ACH failures you will be billed \$25 for each failure.**

Signature of Authorized Signer on Bank Account

Printed Name

Check Reimbursements:

In the event that all of your reimbursement account participants will not be providing Direct Deposit Authorization for manual claim reimbursements, you can agree to have American Benefits Group issue these reimbursements as checks. These checks will be issued from your authorized bank account using the signature of your authorized signer and available starting check numbers that you provide in section below. American Benefits Group provides the check stock needed for writing these checks, you may find a sample in the **Administrator's Guide**. In the case that an employee loses or destroys a check, American Benefits Group will contact you, it is the Employer's responsibility to stop payments on lost or damaged employee checks. Once the check payment has been stopped, ABG will issue the employee a new check.

An image of the signature entered in the box to the right, will be printed on all checks issued pursuant to this agreement. Checks will be issued using the following starting check number . . .

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Signature of Authorized Signer on Bank Account

Printed Name

Either the Company or the Client may terminate this agreement at any time by a notice in writing, mailed to or delivered at the last known address of the other party, and that any payments due at the date of such termination, or thereafter falling due, shall be payable by the Client in accordance its obligations as Administrator under its Reimbursement Plan(s).