AMERICAN BENEFITS GROUP

CLIENT INFORMATION FORM

FLEXIBLE SPENDING ACCOUNTS & HEALTH REIMBURSEMENT ARRANGEMENTS

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-charper "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: _____

City / State / Zip: _____

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:	☐ Yes ☐ No	☐ Yes ☐ No
Email:	Tel:		
Payroll:	Title:	☐ Yes ☐ No	☐ Yes ☐ No
Email:	Tel:		
Billing/Finance:	Title:	☐ Yes ☐ No	☐ Yes ☐ No
Email:	Tel:		
Broker Contact:	Title:	N/A	☐ Yes ☐ 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: _____

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:

_____

_____

_____

Flexible Spending Accounts – Year End Options

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

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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 Caryover 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 _____

HRA Plan Design

Please note that your HRA must comply with the Affordable Care Act (ACA) requirements beginning January 1, 2014 as clarified on September 13, 2013 in Treasury Notice 2013-54. Your HRA can continue to reimburse all or a subset of eligible medical expenses as described under IRS Code Section 213(D) if:

1. Those eligible for the HRA are also eligible for, and enrolled in, an employer-sponsored ACA-compliant group medical coverage. Employer-sponsored ACA-compliant group medical coverage may be provided by the employer that offers the integrated HRA or employees may certify they have coverage under a spouse's or parent's ACA-compliant group medical plan.
2. The group medical plan meets the minimum value requirement.

If you are currently offering an HRA to all of your employees regardless of whether they are enrolled in an ACA compliant group medical plan you must terminate this plan or amend it so that it is only available to employees who have ACA-compliant group medical insurance with minimum value coverage. Please contact American Benefits Group immediately to discuss any changes or amendments you may need to do.

Please confirm that all employees who are eligible to participate in your HRA are:

☐ Enrolled in either your employer sponsored ACA-compliant group medical coverage
or
☐ Have certified that they have coverage under their spouses or parent's ACA compliant group medical plan

If you are currently offering an HRA to all of your employees regardless of whether they are enrolled in an ACA compliant group medical plan you must terminate this plan or amend it so that it is only available to employees who have ACA-compliant group medical insurance. Please contact American Benefits Group immediately to discuss any changes you need to do to your HRA account.

HRA Plan Design

Plan Effective Date: _____

This Plan is: ☐ An entirely new plan ☐ A continuation (amendment or restatement) of an existing plan*
*If so, what was the effective date of the original plan? _____

Who was previously administering the Plan? _____

What is the 3 digit ERISA plan number assigned to this plan? _____

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: _____

Participation in the Health Reimbursement Arrangement Begins (*please check*):

☐ As of date of hire

☐ From date of hire: ☐ 30 days ☐ 60 days ☐ 90 days

☐ First of the month following: ☐ DOH ☐ 30 days ☐ 60 days ☐ 90 days

☐ Other *(please explain)*: _____

Please indicate which employees will be eligible for the HRA:

☐ All Benefit Eligible employees

☐ Health Plan participants only

☐ HSA Plan participants only

☐ Retirees only

☐ Other *(please explain)*: _____

Minimum hours per week worked to participate _____

Linked HRA

Is this HRA linked to a Health Plan? ☐ Yes, please attach a Summary Plan Description for this Health Plan ☐ No

What is the name of your Plan? _____

Is this Plan a High Deductible Health Plan (HDHP)? ☐ Yes ☐ No

Does the deductible run on a calendar year? ☐ Yes ☐ No, indicate the month when the deductible renews: _____

Do you want to want to run a short plan year so that the HRA year coincides with the Linked Health Plan year? ☐ Yes ☐ No

For a linked HRA, please indicate annual amounts:

	DEDUCTIBLE	ER CONTRIBUTION
Single:	$_____	$_____
2 Person:	$_____	$_____
Family:	$_____	$_____

Is there a prescription deductible that the HRA will be funding? ☐ Yes ☐ No

If Yes, is the deductible embedded in the Medical Deductible? ☐ Yes ☐ No

Indicate annual RX deductible amounts:

	DEDUCTIBLE	ER CONTRIBUTION
Single:	$_____	$_____
2 Person:	$_____	$_____
Family:	$_____	$_____

Non-Linked HRAs and HRAs linked to a non-HDHP Health Plans

What coverage tiers are you offering?

☐ Employee only ☐ Employee plus one ☐ Family ☐ Flat Rate

☐ **HRA Plan where the HRA Reimburses eligible expenses first:**

Employee only	***Employee plus one***	***Family***	***Flat Rate***
Employer will pay first	Employer will pay first	Employer will pay first	Employer will pay first
$ _____	$ _____	$ _____	$ _____
Employee will pay second	Employee will pay second	Employee will pay second	Employee will pay second
$ _____	$ _____	$ _____	$ _____

☐ **HRA Plan where the Employee Reimburses eligible expenses first:**

Employee Only	***Employee plus one***	***Family***	***Flat Rate***
Employee will pay first	Employee will pay first	Employee will pay first	Employee will pay first
$ _____	$ _____	$ _____	$ _____
Employer will pay second	Employer will pay second	Employer will pay second	Employer will pay second
$ _____	$ _____	$ _____	$ _____

HRA Plan Design Continued

How are the funds in the HRA made available to your plan participants?

- ☐ 100% at the beginning of the plan year
- ☐ Posted monthly on the first of each month
- ☐ Posted quarterly on the first of each quarter
- ☐ The employer and employee are responsible for a percentage of each expense (the total should equal 100%)

The employee is responsible for: ☐ 25% ☐ 50% ☐ 75% ☐ Other (please specify) _____

The employer is responsible for: ☐ 25% ☐ 50% ☐ 75% ☐ Other (please specify) _____

Will the funds be pro-rated for new hires based on the plan entry date? ☐ Yes Monthly ☐ Yes Quarterly ☐ No

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Do you offer an FSA plan? ☐ Yes ☐ No

If yes, the HRA will pay for all eligible expenses first and the FSA will pay second. If the benefit order is different please note here and describe _____

What expenses can the HRA benefits be used for and do you allow them to be paid for with the ABG Benefits Card
(The card is not suitable for plans which require employees to pay the first portion or their deductible, or for plans which are required to reimburse non-RX deductible expenses.)

Expense	Card	Documentation Required To Substantiate Claim
☐ Deductible Expenses	☐	☐ Yes ☐ EOB
☐ Co-pays	☐	☐ Yes ☐ EOB
☐ Co-Insurance	☐	☐ Yes ☐ EOB
☐ Dental	☐	☐ Yes
☐ Vision	☐	☐ Yes
☐ Over-the-counter	☐	☐ Yes
☐ RX	☐	☐ Yes
☐ Other	☐	☐ Yes

Run Out Period for End of Plan Year – How may days after the end of the Plan Year will employees have to submit claims incurred during the plan year?

☐ 3 months ☐ Other: _____

Participation in the HRA terminates: ☐ Date of Termination ☐ Last day of the month in which termination occurs

Number of days after termination to submit claims incurred prior to termination?

☐ 90 days ☐ Other (please specify) _____

COBRA

Please note that Health Reimbursement Arrangements are governed by ERISA; HIPAA and COBRA regulations. With a COBRA qualifying event an HRA participant must be offered COBRA on their HRA benefit.

What are the COBRA premium rates for your HRA?

Employee Only _____ *Employee plus one* _____ *Family* _____ *Flat Rate* _____

☐ The COBRA premium rate is a bundled rate for both the Integrated Health Plan and the HRA.

☐ There will be separate premium for the Group medical plan and the integrated HRA.

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 . . .

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).