



# AMERICAN BENEFITS GROUP

## CLIENT INFORMATION FORM

### Company Profile

Legal Name of Organization: \_\_\_\_\_ Broker of Record: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
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:		
Contact:	Title:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Tel:		
Broker Contact:		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](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:

**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), the FSA plan's Carryover provision will be automatically permanently indexed to be equivalent to 20% of the federal annual contribution maximum under Section 125 of the IRC for that Plan Year. By statute, the increase to the Section 125(i) limit is rounded to the next lowest multiple of \$50. Increases to the maximum carryover amount, as the result of that indexing, will be in multiples of \$10 (20% of any \$50 increase to the Section 125(i) limit). This initial increase will be \$550 for plans that start/renew in 2020. 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

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

New plan year election minimum: ☐ \$100 ☐ Other \_\_\_\_\_

**Adoption of IRS Special Provisions Include:** \_\_\_\_\_

*Please include copies of your amendments*

## Health Reimbursement Arrangement

### 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 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:	\$ _____	\$ _____

Notes: \_\_\_\_\_

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:	\$ _____	\$ _____

Notes: \_\_\_\_\_

### 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:**

<b>Employee only</b>	<b>Employee plus one</b>	<b>Family</b>	<b>Flat Rate</b>
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 \$ _____

Notes: \_\_\_\_\_

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

<b>Employee Only</b>	<b>Employee plus one</b>	<b>Family</b>	<b>Flat Rate</b>
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 \$ _____

Notes: \_\_\_\_\_

## 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

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
<input type="checkbox"/> Deductible Expenses	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> EOB
<input type="checkbox"/> Co-pays	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> EOB
<input type="checkbox"/> Co-Insurance	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> EOB
<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/> Yes
<input type="checkbox"/> Vision	<input type="checkbox"/>	<input type="checkbox"/> Yes
<input type="checkbox"/> Over-the-counter	<input type="checkbox"/>	<input type="checkbox"/> Yes
<input type="checkbox"/> RX	<input type="checkbox"/>	<input type="checkbox"/> Yes
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/> Yes

**Run Out Period for End of Plan Year** – How many 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.