

**CLIENT INFORMATION FORM**

**COMPANY PROFILE**

Legal Name of Organization: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Executive Officer: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ Company URL: http:// \_\_\_\_\_

Business Activity: \_\_\_\_\_ Under Laws of (State): \_\_\_\_\_

Employer Fed Tax ID#: \_\_\_\_\_ Date of Incorporation: \_\_\_\_\_

Tax Year Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Affiliated Employers (if any): \_\_\_\_\_

Organization Type (*please check*):

- |   |  |
|---|--|
| <input type="checkbox"/> Non-Profit                       | <input type="checkbox"/> Professional Association    |
| <input type="checkbox"/> *Partnership/LLP                 | <input type="checkbox"/> Government Agency           |
| <input type="checkbox"/> *LLC (Limited Liability Company) | <input type="checkbox"/> *Sole Proprietorship        |
| <input type="checkbox"/> *Sub-chapter "S" Corporation     | <input type="checkbox"/> Sub-chapter "C" Corporation |

**\*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.

**PRIMARY CONTACT INFORMATION**

**HR Contact:** \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Backup Contact: \_\_\_\_\_

**Payroll Contact:** \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Backup Contact: \_\_\_\_\_

**Finance Contact:** \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Backup Contact: \_\_\_\_\_

**Billing Contact (for invoices):** \_\_\_\_\_

**ENROLLMENT**

Will you be using **on-line** enrollment?  Yes  No\*

\*If you will not be using on-line enrollment, employee profile and election information must be submitted to American Benefits Group in an excel template (see attached file format specifications).

In order to provide the best possible participant support and communication, employee email addresses are required as part of the enrollment process.

If you feel that this will not be possible please indicate here:  Not possible\*

\*If you check "Not possible," additional fees for communications sent via US Postal Service may apply.

All participants are required to provide their direct deposit information as part of the enrollment process.

If you feel that this will not be possible please indicate here:  Not possible\*

\*If you check "Not possible," please provide check writing account information and either signature cards or a PDF of authorized signatory's signature. Additional fees for reimbursements by check sent via US Postal Service may apply.

Do you want to allow plan participants to make on-line changes to their personal profile information?

(i.e. address, direct deposit info, etc. – NOT benefit changes)  Yes  No

**ELIGIBILITY GUIDELINES**

Open Enrollment Period: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Number of Benefit Eligible Employees: \_\_\_\_\_ Minimum Age for eligibility: \_\_\_\_\_

Participation in the Plan 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): \_\_\_\_\_

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

Full-time: Active \_\_\_\_\_ minimum hours per week worked

Part-time: Active \_\_\_\_\_ minimum hours per week worked

Union     Other (please explain): \_\_\_\_\_

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


Upon employee termination, when does the coverage end? (Card is made inactive on date of termination)

Date of termination

Other: \_\_\_\_\_

**PAYROLL CONTRIBUTIONS**

<b>PAYROLL CONTRIBUTION FREQUENCY (Please complete all applicable fields)</b>					
<b>FREQUENCY</b>	<b>Plan Start Date</b>	<b>Plan End Date</b>	<b>First Payroll Date</b>	<b>Last Payroll Date</b>	<b># of Payrolls Per Plan Year</b>
<b>Monthly</b>					
<b>Semi-Monthly</b>					
<b>Bi-Weekly</b>					
<b>Weekly</b>					
<b>Other</b>					

**Contribution Rounding Procedure:**

All elections will be rounded to the nearest decimal with no adjustments.

**REPORT SCHEDULING**

*Please indicate if you would like to receive any of the following reports. If so, indicate how frequently you would like them scheduled. The reports will be available through the employer administration portal. If you would like email notifications of report availability, indicate the desired email recipient(s).*

**1. Account Balances Report:** View claim summary and account balance information per participant and per plan as of specified date.

Schedule this report?                       Weekly             Monthly             Quarterly

Email Recipient?     HR Contact                       Payroll Contact

Other 1: Name \_\_\_\_\_ Email address: \_\_\_\_\_

Other 2: Name \_\_\_\_\_ Email address: \_\_\_\_\_

**2. Payment Register:** View all reimbursements/payments during a specified time period.

Schedule this report?                       Weekly             Monthly             Quarterly

Email Recipient?     HR Contact                       Payroll Contact

Other 1: Name \_\_\_\_\_ Email address: \_\_\_\_\_

Other 2: Name \_\_\_\_\_ Email address: \_\_\_\_\_

**3. Contribution Billing Report:** A notification containing information on what employee contributions are scheduled for an upcoming payroll date.

Schedule this report?                       Every Pay Period             Other \_\_\_\_\_

Email Recipient?     HR Contact                       Payroll Contact

Other 1: Name \_\_\_\_\_ Email address: \_\_\_\_\_

Other 2: Name \_\_\_\_\_ Email address: \_\_\_\_\_



**COMMUTER BENEFITS SECTION 132 – PLAN DESIGN** (skip this section if you are not offering a Commuter plan)

Under Section 132 of the IRS tax code, an employer can allow employees to set aside a portion of their salary to pay for qualified parking and transit expenses. The employee will not be taxed on these amounts as long as they are used for qualified expenses and do not exceed the statutory monthly limits.

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? \_\_\_\_\_

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: \_\_\_\_\_

Do you wish to offer your employees a Parking benefit\*?       Yes     No

\* The statutory monthly limit of Parking expenses that can be reimbursed using pre-tax dollars is \$230.

If Yes, state the monthly limit you will allow:    \$ \_\_\_\_\_ (pre-tax maximum \$230)

Do you wish to offer your employees a Transportation benefit\*?       Yes     No

\* The statutory monthly limit of Transit expenses that can be reimbursed using pre-tax dollars is \$230 eff. 4/1/2009 per ARRA.

If Yes, state the monthly limit you will allow:    \$ \_\_\_\_\_ (pre-tax maximum \$230)

Will you allow employees to make additional after tax contributions?       Yes     No

How often do you want to allow your employees to make changes to their elections?  
(All changes must be communicated to American Benefits Group via election change forms)

Monthly       Quarterly

**Termination**

Run Out Period - Upon Termination how many days do you want terminated employees to have to submit claims for reimbursement incurred prior to termination?

30 days      60 days      90 days      Other: \_\_\_\_\_

Since Section 132 does not have a “Use it or lose it” provision, unused funds are allowed to rollover, however funds remaining upon termination can only be accessed by submitting claims for expenses incurred while employee was an active participant in the Plan.



**PRE-AUTHORIZED ELECTRONIC BANK DRAFT AGREEMENT  
with AMERICAN BENEFITS GROUP (hereinafter the Company)**

The Company is hereby authorized to make withdrawals from the checking account of the undersigned Flexible Benefit Plan Client (hereinafter the Client) at the bank named herein to pay reimbursement claims submitted by participants of the Client's Flexible Benefits Plan(s) as they become due or within 31 days thereafter.

It is agreed that:

- This authorization shall apply to any and all authorized claims made by duly enrolled participants of said Client's Flexible Benefit Plan(s) and shall be initiated following each payroll period as applicable;
- The debiting of such withdrawals to the checking account of the undersigned Flexible Benefit Plan Client shall constitute due notices of claims being payable to participants of the Plan(s);
- The Company reserves the right to assess a fee for any returned withdrawal not honored by the bank;
- Either the Company or the Client may terminate this agreement at any time by a notice in writing, mailed or delivered to or 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 Flexible Benefits Plan(s).

**CLIENT** (Please Print or Type) \_\_\_\_\_  
COMPANY NAME

\_\_\_\_\_ BANK \_\_\_\_\_ BANK ACCOUNT NUMBER \_\_\_\_\_ ABA NUMBER

\_\_\_\_\_ STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP

\_\_\_\_\_ DATE \_\_\_\_\_ SIGNATURE OF ACCOUNT HOLDER

NEW AGREEMENT       CHANGE OF ACCOUNTS

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