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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*):

- ☐ Non-Profit
- ☐ Professional Association
- ☐ *Partnership/LLP
- ☐ Government Agency
- ☐ *LLC (Limited Liability Company)
- ☐ *Sole Proprietorship
- ☐ *Sub-chapter “S” Corporation
- ☐ 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

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

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:_____________________

FLEXIBLE SPENDING SECTION 125 – PLAN DESIGN (*skip this section if you are not offering an FSA plan*)

Plan Effective Date: ______________________________

This Plan is:

An entirely new plan

An 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:__________

Please select the Section 125 benefits you wish to offer and complete details:

- Medical Premium Conversion
- Dental Premium Conversion
- Medical Reimbursement
- Dependent Care Assistance
- Limited-purpose FSA
- Individually-owned Insurance Premium

Maximum Medical Election: ________________

Minimum Medical Election, if any: ____________ Minimum DCAP Election, if any: ____________

Will Employer Contribute to the plan? Yes* No

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

____

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

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

*If Yes, please indicate the last day claims may be incurred ______________________

Apply Grace Period to Medical FSA? Yes No

Apply Grace Period to Dependent Care FSA? Yes No

Run-Out Period:

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? 90 days Other ________________

Upon termination how many days do you want terminated employees to have to submit claims for reimbursement incurred prior to termination? 90 days Other ________________

DISCRIMINATION TESTING

Discrimination Testing: Groups with Highly Compensated employees (over $100,000) and Key employees (corporate officers or shareholders with more than 5% ownership) are subject to various discrimination tests which may limit the amounts these employees may contribute to medical and Dependent Care Plans. Please indicate if these tests will be necessary: Yes No

HEALTH REIMBURSEMENT ARRANGEMENTS – PLAN DESIGN (*skip this section if you are not offering an HRA)*

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?_____________

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: ____

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

___________________________ ___________________________ ____________________________

___________________________ ___________________________ ____________________________

___________________________ ___________________________ ____________________________

Linked HRA

Is this HRA linked to a Health Plan? ☐ Yes* ☐ No

*If Yes, please attach a Summary Plan Description for this Health Plan

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*

*If No, indicate the month when the deductible renews: ___________________________

Do you want to want to run a short plan year so that the HRA plan 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:	$___________	$___________

HEALTH REIMBURSEMENT ARRANGEMENTS – PLAN DESIGN (*Continued*)

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

Please list in detail the specific medical expenses that are to be allowed:

____

____

____

____

____

____

Will this HRA be funded with different tier structures (i.e. Single, two person, Family, part-time, full-time, etc.)? ☐ Yes* ☐ No

*If Yes, please specify the tiers and the funding provided for each one:

	ER Contribution
Single:	$__________
2 Person:	$__________
Family:	$__________

Employer Contributions

Please indicate how employer contributions will be credited:

Uniform (total employer contribution available from the beginning of the plan year)

Pro-rate annual contributions for new hires? ☐ Yes ☐ No

Monthly accrual

Other (*please describe*) ____

Plan Operation

If the HRA is being used in conjunction with an FSA, please indicate the Benefit Order:

HRA pays first (default) FSA pays first

Please indicate if this is a: Limited Purpose HRA (HSA Compatible HRA) (Dental, Vision expenses only)

Post Deductible HRA Retiree HRA

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?

30 days 60 days 90 days Other: ____________

Run Out Period for Terminated Employees - How many days after the date of their termination will employees have to submit claims incurred prior to their termination date?

30 days 60 days 90 days Other: ___________

Rollovers

Will end of year balances be rolled over? ☐ Yes* ☐ No

*If Yes, indicate what % or dollar amount: ____________ to a maximum of $_______________

Will the use of rollover funds be limited to specific expenses? ☐ Yes* ☐ No

*If Yes, indicate the specific expenses that will be covered:

____

____

____

____

____

Spend Down Option

Will you offer a Spend Down Option* for terminated employees?

*The Spend Down option allows a period of time during which an employee can be reimbursed for medical expenses incurred after termination or retirement. Employees must always be offered COBRA under an HRA but they can choose between COBRA and the Spend Down option if it is made available.

☐ Yes* ☐ No

*If Yes, indicate which events will trigger the option and the % and time frames allowed:

Qualifying Event	Conversion %	Spend Down Period
Termination	____________	__________________
Death	____________	__________________
Disability	____________	__________________
Retirement	____________	__________________
Employee Loss of Eligibility	____________	__________________
USERRA Leave	____________	__________________

Run Out Period - How many days after the end of the Spend Down Period will employees have to submit claims incurred during the Spend Down Period?

30 days 60 days 90 days Other: ___________

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.