

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

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:

- | | |
|---|---|
| <input type="checkbox"/> Medical Premium Conversion | <input type="checkbox"/> Dental Premium Conversion |
| <input type="checkbox"/> Medical Reimbursement | <input type="checkbox"/> Dependent Care Assistance |
| <input type="checkbox"/> Limited-purpose FSA | <input type="checkbox"/> 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



**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.