

**POP/FSA/HRA
Flex Application**
PLEASE PRINT CLEARLY OR TYPE



SECTION 1: EMPLOYER INFORMATION

Legal Company Name:	
Physical Address: City, State, Zip	
Mailing Address: City, State, Zip	
Contact at Business:	Contact Person Title:
Company Phone Number:	Company Fax Number:
Contact Person Phone Number:	Tax Identification Number:
Contact Email Address (Required):	

TYPE OF ENTITY:

Corporation
 Governmental Entity/Church
 S Corporation
 Other _____
 Partnership
 Sole Proprietorship
 Limited Liability Company that is taxed as:
 1. partnership or sole proprietorship, 2. Corp , 3. S -Corp
NOTE: S Corporation shareholders (and their families), partners, self-employed partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in a Cafeteria Plan.

Affiliated Employers: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes –complete section 8</i> Provide Legal Name, Address, EIN, & Entity Type	Health Insurance Provider: _____ Total # of Employees _____ # of Eligible _____
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PLAN WILL BE ADMINISTRATED BY: _____ ICMI/FLEXCONNECT _____ EMPLOYER

SECTION 2: PLAN INFORMATION: ALL PLAN TYPES MUST COMPLETE SECTIONS 1, 2, 3,4,9
A fully completed worksheet must be received by FlexConnect at least 15 days prior to the Effective Date of the Plan.

PLAN DESIGN FOR: STAND ALONE PREMIUM ONLY PLAN (WITH/WITHOUT HSA) SECTION 5
 FULL OR LIMITED FLEX WITH HSA SECTION 6
 HEALTH REIMBURSEMENT ARRANGEMENT (HRA) SECTION 7

WILL THIS REPLACE A CURRENT SECTION 125/HRA PLAN? YES NO **ORIGINAL EFFECTIVE DATE** _____

IF YES, PLEASE ATTACH A COPY OF CURRENT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION.

EFFECTIVE DATE: This is a new Benefit Plan effective as of _____ (hereinafter called the “Effective Date”).

PLAN YEAR (CALENDAR OR FISCAL): *This is the 12-month benefit period. (For example, January 1 to December 31 and typically it runs concurrent with a health plan year or an Employers fiscal year.)*

A. ☒ Begins: _____ ☒ Ends: _____
 (MONTH) (DAY) (MONTH) (DAY)

B. ☒ The first year is a Short Plan Year beginning _____ (You cannot have a short Plan Year if this is a restatement.)
 (MONTH) (DAY) (YEAR)

PLAN NUMBER: *This number is assigned by the Employer and it should be assigned to benefit plans in consecutive order. Numbers cannot be reused.*

501 (typically health insurance plan)
 502
 503
 Other: _____



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Flex Application



SECTION 3: ELIGIBILITY REQUIREMENTS FOR EACH PLAN TYPE

ELIGIBLE CLASS OF EMPLOYEES

- All Employees who satisfy eligibility requirements
- Other-Select from list below
 - Salaried Employees only
 - Hourly Employees only
 - All Employees except:
 - Commissioned Employees
 - Union Employees
 - Leased Employees
 - Part-time Employees, expected to work less than _____ hours per week
 - Nonresident Aliens
 - Other: _____

CONDITIONS FOR ELIGIBILITY (SELECT ONLY ONE)

- Same as Employer's group medical plan. **(Recommended.)**
- For **first** Plan Year **only**, anyone employed on the effective date of the Plan is eligible, **thereafter** (Choose one of following options below):
 - For **all years**, eligibility is a follows (Choose one of following options below):
 - _____ Date of hire (no service required)
 - _____ year after date of hire
 - _____ days after date of hire
 - _____ months after date of hire

ENTRY DATE (SELECT ONLY ONE)

- Same as Employer's group medical plan. **(Recommended)**
- First day of the pay period next following date requirements were met
- Date conditions for eligibility are met
- Dual entry (1st day of Plan Year & 6 months later)
- First Day of Plan Year following date requirements were met
- First day of month following date requirements were met

Section 4: Plan Funding/Contribution/Payroll

☞ Payroll Contact Name: _____ Payroll Contact Phone: _____

Email Address: _____

Does your reporting need to be split by: Location, Duties (ie: teacher/administrative)

Plan will be funded by: Check with electronic spreadsheet ACH with spreadsheet emailed

Payroll Cycle is: Weekly (52) Bi-Weekly (26) Semi-monthly(24) Monthly(12) Other

If you marked Bi-Weekly (26): Do you have 26 payrolls but only deduct from 24? Yes No

First Payroll date after the effective date: _____ Second Payroll date _____

Number of remaining payrolls after effective date: _____

POP/FSA/HRA
Flex Application



SECTION 5: BENEFITS FOR STAND ALONE PREMIUM ONLY PLAN

CONTRIBUTIONS: (If the only employer contributions are paying a portion of the cost of insurance with no cash option, select Salary reduction contribution only)

- Salary reduction contributions **ONLY**
- Employer contribution and Salary Reduction apply. The Employer Contribution will be determined annually and distributed on a pro rata basis each pay period. **AND:**
Is the Employer Contributions convertible to cash? Yes No

PREMIUM PAYMENT ACCOUNTS

Premium Payments may be elected for (select all that apply)...

- Health Insurance Dental Insurance Vision Insurance Cancer Insurance
- Prescription Drug Coverage Other Insurance Coverage not listed (Recommended)

HEALTH SAVINGS ACCOUNTS

Does the health plan provide for a HSA-QUALIFIED HDHP? YES NO

Is ICMI administrating your HSA? Yes No If yes, Annual Fee is to be paid by Employer or Employee.

ENROLLMENT Note: the benefit election period shall be established by the administrator in a nondiscriminatory manner

Do you want automatic enrollment for insured benefits if provided under this plan?

- YES.** (recommended.) All eligible insurance premiums will be deducted pre-tax without any elections needing to be made. If an employee does not want their eligible premiums deducted pre-tax a declination must be completed. Participants shall continue same elections as prior year only for insured benefits.
- NO.** If no then, participants who fail to sign a new election form shall...(select one)
 - be considered to have elected not to participate for upcoming plan year
 - continue same elections as prior year only for insured benefits

SECTION 6: BENEFITS FOR FULL FLEX PLAN

CONTRIBUTIONS: Plan will provide for (If the only employer contributions are paying a portion of the cost of insurance with no cash option, select Salary reduction contribution only)

- Salary reduction contributions **ONLY**
- Employer contribution and Salary Reduction apply. The Employer Contribution will be determined annually and distributed on a pro rata basis each pay period. **AND:**
Are the Employer Contributions convertible to cash? Yes No
Are the Employer Contributions available to use for ALL Accounts? Yes No
Are the Employer Contributions available to use for Health FSA **only**? Yes No
Are the Employer Contributions available to use for Health Savings Accounts **only**? Yes No

ARE THE HEALTH PREMIUM PAYMENTS ELECTED SELF-INSURED BY THE EMPLOYER? Yes No

BENEFIT OPTIONS: Flexible Spending Accounts Will Be Established For (SELECT ALL THAT APPLY)...

- Health Flexible Spending Account (Health FSA) Dependent Care Flexible Spending Account
- Adoption Assistance Flexible Spending Account

PREMIUM PAYMENT ACCOUNTS: Premium Payments may be elected for (select all that apply)...

- Health Insurance Other Insurance Coverage not listed (Recommended)
- Vision Insurance Dental Insurance
- Cancer Insurance Prescription Drug Coverage

**POP/FSA/HRA
Flex Application**



HEALTH SAVINGS ACCOUNTS : Does the health plan provide for an HSA-Qualified HDHP? Yes No

If **YES** was selected and you are offering a health flexible spending account – (Select One)

Health FSA will be limited to the selected expenses for HSA contributing Participants:

- Dental Vision Preventive

No Limited Flex for HSA contributing Participants.

Only Expenses in excess of the HDHP deductible.

Is ICMI administrating your HSA? Yes No If yes, Annual Fee is to be paid by Employer or Employee.

The Health FSA will allow:

◆New elections due to change in status. ◆Prescribed Over-the-Counter Items allowed. ◆A nondiscriminatory Election Period established by Administrator.

✎Health FSA Plan Year limit \$ _____

Individual Health Policies: For Health Insurance, may participants seek premium reimbursement for individual Health policies through the Premium Reimbursement Accounts? These are outside individually owned policies that must be pre-approved prior to effective date of the plan. Some policies types are not eligible.

Yes No *If yes is selected, it is at the plan administrator's discretion*

TERMINATED PARTICIPANTS: Unless continuation of coverage is elected under COBRA, terminated participants will be eligible to submit claims for expenses incurred during the plan year through their date of termination for the remainder of the plan year. Expenses incurred after the date of termination would not be eligible for reimbursement unless continuation of coverage is elected under COBRA.

ENROLLMENT: Do you want Automatic Enrollment for insured benefits if provided under this Plan?

- Yes. (**Recommended.**) All eligible insurance premiums will be deducted pre-tax without any elections needing to be made. If an employee does NOT want their eligible premiums deducted pre-tax a declination must be completed. Participants shall continue same elections as prior year only for insured benefits.
- No. If **NO then**, Participants who fail to sign a new election form shall...(select one)
- No – There is an Employer Contribution. ...(select one)
 - Be considered to have elected not to participate for upcoming Plan Year
 - Continue same elections as prior year only for insured benefits

Note: The Benefit Election Period shall be established by the Administrator in a nondiscriminatory manner.

GRACE PERIOD

- ❖ "Grace Period." Extends the time to incur HFSA expenses past the end of the Plan Year.
- ❖ The Grace Period shall be 2 ½ months after the end of the Plan Year (March 15 for a calendar year plan)
- ❖ Maximum account funds available during the Grace Period is the entire remaining account balance

Do you want to add the grace period? Yes No

If **Yes** was selected, for Health FSA expenses will be available during the Grace Period.

POP/FSA/HRA
Flex Application



RUN-OUT PERIOD: This is the time period that a Participant has to submit claims. Claims for reimbursement must be filed before the end of the Run-out Period.

- a. **If Grace Period Selected:** The Run-Out Period ends the last day of the month in which the Grace Period Ends. For example, for a calendar year plan, if the Grace Period is 2 ½ months (ending March 15th), then the Run-Out Period ends March 31st. **Note: If the grace period is selected, the run-out period may not end prior to the grace period.**
- b. **If Grace Period NOT Selected:** The Run-Out Period ends the last day of the _____ month following the end of the plan year:
 - 2nd Month (for example, for a calendar year plan, the Run-Out Period ends the last day of February)
 - 3rd Month (for example, for a calendar year plan, the Run-Out Period ends the last day of March)

DEBIT CARDS: Will debit cards be provided for employees electing this option?

- Yes – An annual fee of \$24 will be deductible from each card participant’s HFSA account.
- Yes – An annual fee of \$24 will be paid by the employer.
- No – I don’t want debit cards available to my employees. If debit cards are later desired there could be a charge to change the plan document.

FAMILY AND MEDICAL LEAVE ACT: The plan provides language for FMLA. Applies to Employers with 50 or More Employees in a 75 Mile Radius

COBRA: The plan provides language for COBRA. Applies to Employers who employs more than 20 employees on a typical business day.

HIPAA: The plan provides language for HIPAA

WRAP Plan: Is this Plan a “wrap” plan for Form 5500 filing purposes? Yes No

HEART ACT: ADD (QUALIFIED RESERVIST DISTRIBUTION- QRD) provisions for Health FSA. Yes No
If Yes : Select Distribution Amount (all amounts minus reimbursements paid) (select one)

- the beginning of year FSA amount or
- amount contributed up to point of distribution request

How many distribution per year? _____

****Claims submitted after QRD (select one)**

- be paid on submission as any other claim or
- shall not be paid

SIMPLE CAFETERIA PLAN (for employers with 100 or fewer employees): Safe Harbor Provision for Small Employer – A small employer is one who employs 100 or fewer employees during either of the two years preceding the year for which the discrimination test is being run.

Yes (complete remaining selections) **No**

- Effective _____
- Employer Contribution shall be _____% (not less than 2% of a Participant’s contribution) or a matching contribution equal to _____% of compensation but in no event more than _____% (cannot be less than 6% of compensation).

Contribution are convertible to cash: YES or NO

SECTION 7: BENEFITS FOR HEALTH REIMBURSEMENT PLAN (HRA)

If the company is requiring employers pay a “premium” for this HRA benefit, contact our office for customization.

Are the health premium payments elected above self-insured by employer? YES or NO

MAXIMUM BENEFIT PER COVERAGE PERIOD:

- Single ⌘ \$ _____
- Family ⌘ \$ _____
- Other ⌘ \$ _____

MAXIMUM BENEFIT PER COVERAGE PERIOD APPLIES to:

- Employee only
- Employee and dependents

SHALL REIMBURSE: (SELECT ALL THAT APPLY)

- Co-payments under the Employer’s group medical plan
- Deductibles under the Employers group medical plan Is the deductible Embedded Yes No
- All medical expenses within the meaning of Code Section 213
- The following types of medical expenses only: ⌘ _____

- Other ⌘ _____

IF YOU SELECTED DEDUCTIBLES THE HRA WILL REIMBURSE:

- At split levels (i.e. 80/20) ⌘ _____ up to \$ _____ per employee and \$ _____ per family.
- First Dollar coverage applied to deductible: ⌘ \$ _____ single, first dollar coverage applied to deductible: \$ _____ family
- First Dollar coverage of all 213 medical expenses: ⌘ \$ _____ single, \$ _____ family

COVERAGE PERIOD: Schedule on which benefits under plan will become available for eligible employees

- Monthly Quarterly Annual Calendar Year Annual Plan Year

HRA CARRY FORWARD - amounts not used during a coverage period shall:

- Be carried forward to the next Coverage Period without limitation as to the maximum accumulation.
- Be carried forward to the next Coverage Period, in an amount up to ⌘ \$ _____. However the maximum accumulation limit for a Coverage Period is ⌘ \$ _____.
- Shall be forfeited

IF THE EMPLOYER MAINTAINS A FLEXIBLE BENEFIT PLAN THAT INCLUDES A HEALTH FLEXIBLE SPENDING ACCOUNT, WHICH PLAN SHALL PAY EXPENSES FIRST?

- This plan (Health Reimbursement Arrangement)
- The Health Flexible Spending Account under the Employer’s Flexible Benefit Plan
- If the HRA is selected as the first pay, shall unpaid balances automatically roll to the FSA account if one is present? (this is a company level setting, not an individual setting)
- Other ⌘ _____
- Will this plan pay to election (in the case of deductible based plans) or Pay to deposit (in the case of designs where the employee receives employer money into the HRA account and the funds roll from year to year?)

“PAY TO PROVIDER ONLY” OPTION FOR THE HRA ACCOUNT, IF GROUP HAS BCBS INSURANCE, CLAIMS WILL BE TRANSMITTED TO ICMI FROM BCBS AND PAID DIRECTLY TO PROVIDER.

- Yes No

**POP/FSA/HRA
Flex Application**



SECTION 9 Signatures Required

A fully completed worksheet must be received by FlexConnect at least 15 days prior to the Effective Date of the Plan.

Review: *Please confirm the required sections were completed prior to submission.*

- Stand Alone Premium Only Plan: **sections 1, 2, 3, 4, 5, 9**
- Full Flex Plan: **sections 1, 2, 3, 4, 6, 9**
- HRA: **sections 1, 2, 3, 4, 7, 9**

Document and Customized Forms are to be emailed: (email address must be provided)

- Directly to Agent
- Directly to Employer

Fees: *By signing below, I agree to the fees set forth in: (select one)*

- Proposal Provided
- Based on Fee Sheet

Employer's Authorized Representative: _____ **Date:** _____

Employer understands that by law, the Plan document must be signed and effective prior to starting any payroll deductions.

Consultant/Agent: _____ **Date:** _____

Consultant Address: _____

Telephone _____ **E-mail address** _____

Comments/Special Instructions