FSA/HSA
EMPLOYER APPLICATION

Please complete this form and send it with fee payable to:
Benefit Advantage, Attn: Finance, P.O. Box 5490, De Pere, WI 54115-5490

Employer Name: ______________________________ Total # of EE's: ________

(Enter name **EXACTLY** as it appears on tax returns and is to appear in documents.)

Owner: ______________________ Main Contact: ______________________

Accts Payable Contact: ______________________ Title: ______________________

Address: ____

Phone # ______________ Fax #______________ Email______________ Tax ID# ____________

ORGANIZATION TYPE: (Federal Classification)

- ☐ Corporation
- ☐ Sub-chapter "S" Corporation
- ☐ Professional Corporation
- ☐ Professional Association
- ☐ Partnership
- ☐ Sole Proprietorship
- ☐ Government Agency
- ☐ LLC Limited Liability Company
- ☐ Other (specify):______________________________________

The Employer/Organization entity is operating pursuant to the laws of the State of:______________

Date Incorporated: _____/_____/______

Nature of Business (**BE SPECIFIC**): ______________________________________

Principal Business Activity Code (six digits): _____ _____ _____ _____ _____ _____

Note: Per IRS Regulations, Section 125 excludes sole proprietors, partners, and individuals owning 2% or more shares in an S-Corporation (along with their immediate family members from participating in this plan. They may, however, sponsor the plan for their employees.

Plan Year Information:

Initial Plan year: Effective Date ______/______/______ through ______/______/______

Subsequent plan years: Effective Date ______/______/______ through ______/______/______

Payroll Frequency: (check all that apply) ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

Payroll Date - The first payroll date the pre-tax deductions will be withheld on is:__________________

Note: Deductions withheld within the plan year should be posted to that plan year.

Number of payrolls first plan year: ______________each following plan year: ______________

If there are other divisions participating, will the deductions be sent all together with one form of payment? ☐**Y** or ☐**N**

If no, please list each division and contact name responsible for the deduction payments, and payroll frequency: ______________________

____

Plan Number - The number assigned to this plan is _________ (i.e., 501, 502, etc. based on the filing Form 5500)

Eligibility Requirements - Each new employee shall be eligible to participate in the plan after they satisfy the following criteria:

Age Limitations: ☐**Y** or ☐**N** If yes, an employee must be at least _______ #years old in order to participate in this plan.

Hours of Service: ☐**Y** or ☐**N** If yes, an employee must work ________#hours for the employer to participate in this plan.

Length of Service Limitations: ☐**Y** or ☐**N** If yes, please specify below:

An employee must work: (fill in one) ________ #days, or ________# months, or ________ #years before participating in this plan

Coverage Effective Date:

- ☐ Immediate after service limitations are met.
- ☐ Coverage begins on the first of the (check one) ☐ month ☐ year ☐ quarter after service limitations are met.

Employment Classification Limitations: ☐ **Y** or ☐ **N** If yes, please check all that apply:

☐ Salaried ☐ Hourly ☐ Union

Is the employer part of a control group of entities or an affiliated service group? ☐ **Y** or ☐ **N**

If yes, please list: ______________________________

Claim Submission Periods:

The Closing Period is the period of time that begins at the Plan Year end during which the employee can submit claims for payment of Qualified Expenses under that Plan Year. This period begins at the end of the Plan year and terminates **(check one):**

☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify):__________________ after the end of the current FSA plan year.

Note: The closing period for termed employees would be the same as stated above.

Will your plan include an additional grace period extension: ☐ Y ☐ N

Which plans will it apply to: ☐ Medical Reimbursement ☐ Limited Medical Reimbursement

Length of Grace Period: ☐ Add 2-1/2 month grace period ☐ Other (specify)______________________________

grace period limited to 2-1/2 months

Incorporate grace period with: ☐ run out period ☐ separate

Note: All claims will be paid from the prior plan year when the grace period is incorporated

Will you allow claim reprocessing: ☐ Y ☐ N

Will you be implementing the debit card? ☐Y ☐N If yes, a Debit Card Application must be completed.

Section 125 Cafeteria Benefits (check **all** benefits to be offered) **NOTE:** Premium Only Plan (POP) is included in this plan.

☐ AD&D ☐ Dental ☐ Health ☐ LTD ☐ Life ☐ Prescription ☐ STD ☐ Vision

List any other coverage: ______________________________

☐ Health Flexible Spending Account (FSA)

☐ Limited FSA

☐ Dependent Care Expense Flexible Spending Account (FSA)

☐ Premium Reimbursement (individual health premiums **ONLY**)

☐ HSA (employee deduction)

Annual Contribution Limit

The IRS stipulates the employer must make the annual election for the Health FSA available for reimbursement as of the first day of the Plan Year. The maximum annual amount cannot be more than the lowest paid eligible employee's gross annual income.

Maximum Annual Election for the Health FSA $______________ **(required)** Minimum Annual Contribution $____________ **(optional)**

Maximum Annual Election for the Dependent Care FSA $___________ **(required)** Minimum Annual Contribution $_________ **(optional)**

The IRS states the maximum annual contribution for Dependent Care Expense FSA is $5,000; $2500 if married, filing separately.

Note: The Dependent Care Expense Account only allows for the balance in that account to be available for reimbursement after the service is rendered.

Employer (Annual Max) Contribution **(optional) $**_________ Payments will be made per: (check one) ☐ pay period ☐ month ☐ year

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Program Funding Arrangements:

☐ **ACH** – Benefit Advantage initiates the transfer for payroll deductions. Administration fees will be pulled ACH also.
The employer sends backup detail for each payroll deduction via fax (920-339-0038) or email (fsadeposits@benadvan.com).

☐ **Manual Check** – The employer sends payment along with backup detail for each payroll deduction to:
Benefit Advantage, PO Box 5546, De Pere, WI 54115

Agent/Broker Name: ______________________________
Phone:

BA Consultant: ____________ Customer # ____________ Plan Doc Fee: ____________ Collected: ☐ Y or ☐ N

Per Participant Fee: ____________ Renewal Fee: ____________

Benefit Advantage, Inc. sends to clients a Welcome Kit which includes verification of pricing and a standard service agreement. Please sign, date, and return. Failure to sign, date and return while accepting services will be viewed as acceptance of our standard business terms and conditions.