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SECTION 125 EMPLOYER APPLICATION (POP, FSA AND DCA)

I. EMPLOYER INFORMATION

Employer Name:		Tax ID #:	
Business Structure*:		State Organized In:	
Mailing Address:	City:	State:	Zip:
Street Address (if different):	City:	State:	Zip:
Telephone:	Fax:		
Are there any Affiliated Companies that are also eligible for this benefit? ☐ Yes ☐ No			
* Reminder: Shareholders that are 2% owners of Sub-S corporations, C- corporations' owners not taking a W-2, partners and LLC members are taxed individually. Therefore, a shareholder is not an employee and is not eligible to participate in the FSA. Similarly, the spouse, parents, children, and grandchildren of 2% or more owners can't participate in the FSA.			

II. IMPORTANT CONTACT INFORMATION

Contact Name	Phone #	Email	Type of Contact (check all that apply)	Portal Access
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing	☐ Yes ☐ No
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing	☐ Yes ☐ No
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing	☐ Yes ☐ No
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing	☐ Yes ☐ No
Broker Agency:			Phone #:	Portal Access
Broker Contact Name	Phone #	Email	Type of Contact (check all that apply)	(to be completed by broker)
			☐ Primary ☐ Secondary ☐ Account Manager ☐ Producer	☐ Yes ☐ No
			☐ Primary ☐ Secondary ☐ Account Manager ☐ Producer	☐ Yes ☐ No

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III. PLAN ELIGIBILITY

Please enter the requirements in order for an employee to be eligible for these plans below, as well as some information on how many employees are employed, and eligible.

Plan	Hours Worked per week:	Length of employment:
Premium Offset Plan (Conversion Plan) (POP)		
Health Reimbursement Account (FSA)		
Dependent Care Reimbursement Account (DCA)		
Total # of employees:	Total # eligible:	
Will you require your reporting to be listed by division? ☐ Yes ☐ No *If **yes**, list the name for each division:* _____		

IV. GENERAL ADMINISTRATION QUESTIONS

Health FSA's are COBRA Eligible Accounts per Federal COBRA Rules. Who handles the COBRA administration when an employee terminates?

_____

Do you want to allow True Substantiation? ☐ Yes ☐ No

If 'Yes' indicate your medical, dental and vision carriers:

_____

True Substantiation allows HRCTS to Harvest Explanation of Benefits (EOBs) directly from medical, dental or vision carrier's portal on behalf of each employee to substantiate their debit card purchases. ***Please note on True Substantiation that we need to verify your insurance carrier is participating. Additional fees do apply.***

V. PLAN DESIGN

Please fully complete the below section to ensure accuracy of plan set up.

1. Original Effective Date of Section 125 Cafeteria Plan:

2. Plan Year:

3. Will this be a short plan year? ☐Yes ☐No

3A. If 'Yes' indicate Next plan year:

3B. FSA Maximum for Short Year: $_____ FSA Maximum for full Year: $_____
DCA Maximum for Short Year: $_____ DCA Maximum for full Year: $_____
*Maximum must be prorated for short plan year based on IRS maximum

Premium offset Plan: ☐Yes ☐No (This is part of S125 plan that allows you to take premiums out pretax.)

Check those which apply: ☐ Medical ☐ Dental ☐ Vision ☐ Other: _____

Health Care Flexible Spending Account: ☐Yes ☐No

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Maximum: ☐ IRS Maximum ☐ Custom: $_____ Minimum: $_____	Employer Contribution: $_____
☐ Rollover Allowed; Amount: $_____ OR ☐ 2 ½ Month Grace Period Allowed Do you currently have the rollover on your plan? ☐Yes ☐No	
Plan includes a 90-day runout period by default.	

Limited Flexible Spending Account: ☐Yes ☐No	
Maximum: ☐ IRS Maximum ☐ Custom: $_____ Minimum: $_____	Employer Contribution: $_____
☐ Rollover Allowed; Amount: $_____ OR ☐ 2 ½ Month Grace Period Allowed	
Plan includes a 90-day runout period by default.	

Dependent Care Flexible Spending Account: ☐Yes ☐No	
Maximum: ☐ IRS Maximum ☐ Custom: $_____ Minimum: $_____	Employer Contribution: $_____
☐ 2 ½ Month Grace Period Allowed	
Plan includes a 90-day runout period by default.	

VI. PAYROLL INFORMATION

Payroll Cycle (check all that apply): ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly	
1st Payroll Deduction in new plan year: _____	Number of Payroll deductions this year: _____

VII. ENROLLMENT METHOD

☐ Online Enrollment through HRCTS System ☐ Excel Spreadsheet
☐ Paper Enrollment Forms ☐ Employer enroll online
☐ Internal Online Enrollment System (with direct feed to our SFTP; setup required)
☐ EDI file integration Who is your EDI file vendor? _____

VIII. FEES AND SIGNATURES

Please review this application carefully, then please read and sign that you agree to the below fees.

Setup Fee: $	Annual Renewal Fee: $
PEPM Fee: $	Monthly Minimum Billing: $
Combined Account Fees: $	
There will be a funding deposit required for this account administration. The amount is determined after initial enrollment and is the equivalent of two months' deductions or $2,000 whichever is greater.	

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Comments:		
Authorized Signer's Name (print)	Title	Date
Signature:		