

Application – Large Business Employer Groups

General employer group information

Group name (must be full legal name)				
Group number		Group EIN		Phone
Group address		City	State	Zip
Plan status <input type="checkbox"/> New plan <input type="checkbox"/> Reinstatement of prior plan	Flex plan name (different than health plan name)	Initial effective date	Renewal month	
Contact for service of legal process (title only)		Employer entity <input type="checkbox"/> C-Corporation <input type="checkbox"/> S-Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Corporation <input type="checkbox"/> Governmental Entity <input type="checkbox"/> Other: _____		
The following individuals are not considered employees and therefore, are not eligible to participate in the FSA: <ul style="list-style-type: none"> • Self employed individuals • Partners in a partnership • Shareholder owning more than 2% in a sub-chapter S-Corporation 				
Sales representative				
Is the employer subject to ERISA (Employee Retirement Income Security Act of 1974 — Schools, churches and cities are usually not subject)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the ERISA plan number? _____				

Component program selections (select all that may apply)

- Health Care FSA
 Dependent Care Assistance Program
 Limited purpose health account (allows HSA participants to participate in Health Care FSA)
 Pre-tax premium contribution program

Health Care FSA

Employee eligibility

- Regularly scheduled to work at least _____ hours per week
 Waiting period of _____ days/months/years after date of hire

Entry date into plan

- First day of month following date conditions for eligibility are met
 Date conditions for eligibility are met

Definition of dependent

- Same as health plan
 IRS definition of dependent

Contributions

Maximum contribution is \$ _____ each plan year
 Minimum contribution is \$ _____ each plan year
 If the employer is contributing money into the Health Care FSA, please list the amount: \$ _____

Does the employer contribution apply to everyone? Yes No
 If no, to whom does it apply? Are there conditions that must be met to qualify? Please explain.

Dependent Care Assistance Program (DCAP)

Eligibility

- Regularly scheduled to work at least _____ hours per week
- Waiting period of _____ days/months/year after date of hire

Entry date into plan

- First day of month following date conditions for eligibility are met
- Date conditions for eligibility are met

Contributions

Maximum contribution is \$ 5,000 each plan year

Minimum contribution is \$ _____ each plan year

If the employer is contributing money into the Dependent Care FSA, please list the amount: \$ _____

Payroll information

Designate payroll information for each class (examples: active, COBRA, hourly, salary, etc.)

Class ID	Payroll frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	Date of first payroll
Class ID	Payroll frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	Date of first payroll
Class ID	Payroll frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	Date of first payroll

Are premium contributions from the employee's salary pre-taxed? Yes No

If yes, what products? (medical, dental, vision, etc.) _____

Miscellaneous FSA options

Number of run-out days to **submit** claims for reimbursement: _____ (standard is 90 run-out days)

Allow 2½ month grace period: (Grace period extends the plan year for an additional 2½ months to **incur** expenses).

- Yes No

If yes, list the number of days in those 2½ months _____

If yes, the grace period should apply to: Health Care FSA DCAP Both

Both the run-out days and the grace period days start at the end of the plan year (run concurrent). Example for 90 run-out days: If the 2½ months grace period is 75 days, then the employee would have 15 additional days to **submit** claims for reimbursement.

If an employee comes on to the plan mid-year, will electable amount(s) be prorated, or can the employee elect the full amount?

- Prorate Full Amount

Do you wish to include the optional HEART Act? This provision allows Section 125 plans to permit military reservists who are called to active duty for over 180 days to receive their full Health Care FSA balance. Yes No

For Limited Health Care FSA only

Do you allow employees who are enrolled in a High Deductible Health Plan (HDHP) other than **your** HDHP to participate in the Limited FSA? Example: an employee opts out of your coverage but is covered under his/her spouse's HDHP. Will you allow this employee to participate in your Limited FSA? If yes, it is your responsibility to verify that the plan is a qualifying HDHP. Yes No

Does the employer make HSA contributions? Yes No

Are contributions deposited into the employees' HSA accounts? Yes No

Can employees have pre-tax salary deductions deposited into their HSA accounts? Yes No

Legal information

Is there a signed Business Associate Agreement on file? Yes No - Contact your sales representative with questions.

FSA fees disclosed

Administration fees	Monthly maintenance (per enrolled participant per month)	One-time set-up
PriorityFSA - Health care and dependent care	\$4.25	\$500
PriorityFSA - Dependent care only	\$3.25	\$500
PriorityFSA - Health care only	\$3.25	\$500

Please note that FSA fees are billed on separate invoices and are not included on the fully funded insurance premium bill. Priority Health assumes that payment for FSA fees will follow the same premium payment method. For example, if the employer has chosen to pay insurance premiums through EFT, FSA fees will also be paid through EFT.

Weekly funding of FSA claims

All FSA reports are stored in the Filemart tool on the Employer Center at *priorityhealth.com*. Individuals assigned by the employer group may access these reports once they have created a username and password on the Employer Center at *priorityhealth.com*.

PHI indicates all details of a claim and **does** contain protected health information. No PHI indicates what checks were written and to whom they were sent and **does not** contain protected health information.

List designated individuals to receive Weekly Funding Reports:

Name	User ID	
		<input type="checkbox"/> PHI <input type="checkbox"/> No PHI
		<input type="checkbox"/> PHI <input type="checkbox"/> No PHI
		<input type="checkbox"/> PHI <input type="checkbox"/> No PHI

Banking set-up

Will subgroups require separate banking arrangements? Yes No

If yes, attach banking set-up information for each subgroup.

Employer funding contact:

Phone

Fax

E-mail

Funding account options

PHMB general account – Complete ACH transfer form

This funding arrangement allows the employer group to utilize a Priority Health bank account that has been established specifically to generate checks for FSA funding. Priority Health ACH transfers the needed funding from the employer's designated account into the general account. Priority Health maintains and reconciles this account.

Check Register to client on Wednesdays via FileMart. Priority Health transfers funds by ACH from client's account into PHMB account on Friday. Checks released.

Please include and send to the Priority Health sales representative one of the following: a voided check, copy of a voided check, copy of bank statement or a letter from the bank to verify account numbers.

Funding account options, continued

Individual account (available for large groups only — 50+ eligible employees)

This option is an employer maintained account. With this option, the employer group must maintain sufficient funds in the account to insure that funds are available for Priority Health to cover the FSA reimbursement. Priority Health will then release checks directly to the member.

An additional \$150 will be charged to laser signature on checks

Option 1 – Zero Balance Account. No approval required, checks released on the same day as funding notification

Option 2 – Assume two days. No approval required, checks released two days after funding notification

Beginning Check Number _____

Please include and send to Priority Health sales representative:

- ABF Signature collection form (original hard copy required)
- MICR specification sheet (produced by the bank)
- One of the following: a voided check, copy of a voided check, copy of a bank statement or a letter from the bank to verify account numbers

PHMB general account authorization to honor certain transactions

Name of financial institution:			
Address	City	State	Zip Code
Contact name (at financial institution):		Branch	
Bank account number	<input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Bank routing number	Contact phone number		
This account has ACH positive pay: <input type="checkbox"/> Yes <input type="checkbox"/> No			

The undersigned hereby requests and authorizes you to pay and charge the bank account noted above (the “Account”) for debit entries or checks drawn on National City and payable to **Priority Health Managed Benefits, Inc.**, or National City; provided there are sufficient funds in the Account at the time of presentation. The undersigned further agrees that the bank’s rights with respect to each such check or debit entry shall be the same as if it were a check or debit entry drawn on the bank and signed personally by the undersigned. So long as this authority shall remain in effect, the undersigned shall indemnify the bank against any claims for honoring any checks or debit entries authorized hereby.

This authority shall remain in effect until revoked in writing by the undersigned.

Company name	
Group number	
Subgroup	
Authorized signature	
Printed name and title	
Date	