

**General employer group information**

Group name:

Group number:	Group EIN:		
Group address:	City	State	Zip

FSA benefit year start date:

Plan renewal day (MM/DD):

Contact for legal process (title only):

Sales representative:

**Component program selected**

Health flexible spending program

Dependent care program

Limited purpose health flexible spending program (allows HSA participants to participate in health flexible spending program)

**Contribution maximums**

For health flexible spending account

\$1,000     \$1,500     \$2,000     \$2,500     \$3,000     Other: \_\_\_\_\_

**Note:** The maximum contribution for dependent care accounts is \$5,000

**Health FSA employer contributions**

If the employer is contributing money into the Health FSAs, list that amount here.

\$ \_\_\_\_\_

**Eligible Class/Plan Information (Active/COBRA)**

Class ID:	Class name:

**Payroll cycle information for dependent care FSA**

Class ID	Payroll deduction frequency	First pay date in plan year
	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice per month <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly                      Other: _____	
	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice per month <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly                      Other: _____	
	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice per month <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly                      Other: _____	

**Business associate agreement**

Is there a signed Business Associate Agreement on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No Contact the small business department at Priority Health for questions.
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**FSA fees disclosed**

Reimbursement Fees	Monthly Maintenance (per enrolled participant per month)	One time set-up charge
<input type="checkbox"/> <b>Priority</b> FSA – Healthcare & Dependent Care	\$4.25	\$500
<input type="checkbox"/> <b>Priority</b> FSA – Dependent Care only	\$3.25	\$500
<input type="checkbox"/> <b>Priority</b> FSA – Healthcare only	\$3.25	\$500

- Please note that FSA fees are 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 you may access these reports once they have been assigned a username and password.

The **Check Register Detail** indicates all details of a claim and **does** contain PHI (private health information).

**Check Register Aggregate** indicates what checks were written and to whom they were sent and **does not** contain PHI.

List designated individuals to receive Weekly funding reports:

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

**Banking set-up**

Will subgroups require separate banking arrangements?	<input type="checkbox"/> Yes If yes, attach banking set-up information for each Subgroup.
	<input type="checkbox"/> No

Contact at employer for funding questions:

Phone number:

Fax number:

e-mail address:

Funding account details

**PHMB General Account – Complete page 3**

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.

Each Wednesday, you'll receive a notification via e-mail with a link to the funding report. Enter your user name and password to download/view the report. Claims are pre-authorized and funding will be debited from your bank account on Friday. Checks will be cut that same day.

**Important:** Please include either a voided check, copy of a voided check, copy of a statement, or a bank letter with this application.

This is the only FSA funding option available.

PHMB General Account Authorization  
to Honor Certain Transactions

Name of financial institution \_\_\_\_\_

Street address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Branch \_\_\_\_\_

Bank account number  Checking  Savings \_\_\_\_\_

Bank routing number \_\_\_\_\_

Contact name (at financial institution) \_\_\_\_\_

Contact's telephone number \_\_\_\_\_

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 \_\_\_\_\_

Sub group \_\_\_\_\_

Authorized signature: \_\_\_\_\_

Name and title: \_\_\_\_\_

Date: \_\_\_\_\_