

Flexible Spending Arrangement Plan Implementation

Employer Legal Name _____ Federal Employer ID No. / Tax ID No. _____

Mailing Address _____ City, State, and Zip Code _____

Primary Contact Name /Title _____ Phone _____ Fax _____ Email _____

Secondary Contact Name/Title (if applicable) _____ Phone _____ Fax _____ Email _____

Invoice Admin Fees Contact Name _____ Phone _____ Fax _____ Email _____

Organization Type:

C-Corporation
 Sub-Chapter "S" Corporation
 Sole Proprietorship
 Partnership
 LLC
 Other _____

Administration Data

Plan Year Start and End dates: From: / / To: / /

Open Enrollment Start and End dates: From: / / To: / /

Total number of employees: _____ Total number of eligible employees: _____

Is this a new FSA plan or an existing FSA plan?

New Plan - (this is the first time implementing an FSA plan)

Existing Plan - (you had an FSA in place last year through a previous TPA) **Prior Plan Year End Date:** _____

****If this is an existing plan, please provide a copy of your current Plan Document and SPD****

Total number of employees participating in the prior plan year: _____

Will Asure be handling your Grace Period and/or Run-Out Period?

Yes
 No, previous TPA is handling
 N/A – This is a new plan

If yes, please confirm the periods: Grace Period - _____ days Run-Out Period - _____ days

****To handle your grace period and/or run-out period, please provide us with a Year To Date Plan Summary report with your participant's election and balance information****

Full Plan Name: _____ **State of Plan's Origin:** _____

Original Plan Effective Date: _____ **IRS Plan Number:** _____

Plan Design

What are the minimum/maximum annual contribution amounts that your plan permits on the following services?

	ANNUAL MINIMUM ELECTION	ANNUAL MAXIMUM ELECTION
HEALTHCARE FSA	\$	\$2,650 maximum IRS limitation
DEPENDENT CARE FSA	\$	\$5,000 (single/married filing jointly) \$2,500 (married filing separately)
LIMITED FSA	\$	\$2,650 maximum IRS limitation

Would you like to offer the Benefits Debit Card?

This card can be utilized for Health and Dependent Care FSA eligible expenses at authorized merchants. (no additional charge applies for employee card)

- No Yes

Would you like to offer a Carryover option (not required by IRS/maximum is \$500)?

The Carryover option permitted under IRS Notice 2013-71 allows Health FSAs participants the option of carrying over up to \$500 at the end of the plan year, to be used for qualified medical expenses incurred in a subsequent plan year. The maximum amount allowed must be the same across all participants. This option can be offered with a Run-Out Period but **cannot** be offered with a Grace Period.

- No Yes – carryover amount up to \$500: \$ _____

Would you like to offer a Grace Period (not required by IRS/maximum is 2 ½ months)?

The Grace Period permitted under IRS Notice 2005-42 extends the time during which expenses may be incurred. It is different from a claim run-out period & may be offered with or without a run-out period. The Grace Period only applies to employees who were active with the FSA on the last day of the Plan Year. The Grace Period does not apply to employees that terminate employment before the end of the plan year.

- No Yes – _____ Months

Would you like to offer a Run-Out Period (not required by IRS/maximum is 90 days)?

The Run-Out Period permitted under IRS Notice 2005-42 extends the time for submitting expenses that were incurred during the coverage period (FSA plan year). The run-out period may be offered with or without a grace period or carryover option. If offered with a grace period, the run-out period would begin after the grace period. If offered with a carryover option, reimbursement claims submitted will use current year contributions first and then use carryover contributions.

- No Yes – _____ Days

Payroll/Contribution Frequency (Please indicate if more than one):

- Semi-Monthly Bi-Weekly Weekly Monthly

ATTACH A COPY OF YOUR PAYROLL CALENDAR DEDUCTIONS FOR THE FSA PLAN YEAR

Are all employees eligible for this plan? _____ If there are exclusions, please indicate:

- Part-time employees who work less than _____ hours per week
- Employees with less than _____ months of employment
- Employees under age _____
- Contract employees
- Other _____

When does participation commence for a new eligible employee (waiting period)?

- No waiting period. Participation begins upon becoming an eligible employee
- First day of the month following upon becoming an eligible employee
- First of the month following 30 days upon becoming an eligible employee
- Only during Open Enrollment following upon becoming an eligible employee
- Other _____

Do you want to allow mid-year elections changes for a qualifying change in status?

- Yes
- No

A change in status must be reported to the plan administrator within 30 days. The FSA election change will be effective the first of the month following receipt of the *Qualifying Election Change* form. The employer should begin withholding the new FSA election amount the first pay period of the month following the effective date of the change.

When does the FSA participation cease for a terminated employee?

- Date of Termination
- The last day of the month following Date of Termination

What is the claim submission period for terminated employees to submit claims that incurred prior to their termination date?

- 90 days
- Other _____

Would you like to implement the “Spend-Down” provision for the Dependent Care Participants? This allows a terminated Dependent Care participant to continue using their available funds after they’ve ceased to be a participant, through the end of the plan year.

- Yes
- No

How are FMLA contributions to be paid? This only applies to companies with 50+ employees. (Prepayment must be offered if either Pay-As-You-Go or the Catch-Up options are offered):

- Prepayment
- Pay-As-You-Go
- Catch-up Option

Does your company have departments, locations, subsidiaries or branches that you would like us to setup in our system for reporting purposes?

- No
- Yes (if yes, please specify the department, location and/or branch names and if you have specific codes you would like us to utilize)

- Departments
- Locations
- Subsidiaries
- Branches

Do all of your departments, locations, or branches use the same bank account?

- No
- Yes

Asure will write checks off of the employer's assigned account (specified below). After each scheduled check run, Asure will email the contacts listed below, the check run register.

Employer's Banking Information:

Are funds held in an employer sponsored trust account? _____ Name of Bank: _____

Bank Address: _____ City/State/Zip: _____

Name on Account: _____ Account Number: _____

Bank Routing No. (MICR) (Ex: 123456789): _____ Bank Routing No. (Bank Info) (Ex. 111-42-348): _____

Authorized Signature(s) to use on Checks:

(Please sign in the box with **BLACK** ink)

Asure will use this signature when creating your check template.

FSA Starting Check Number: _____

(Please specify the check number CSI should use for the FSA reimbursements. 500 will be used if a number is not specified)

****Please provide a voided check (or copy of one if returning by fax or email) from the bank account you want Asure to utilize for your FSA reimbursements. This account should be a general operating account. ****

Manual Claims Reimbursement Frequency:

- Daily (as claims are processed) Weekly (Mondays)

Which Reimbursement Options would you like to offer to your employees:

- Check Direct Deposit

Who within your organization would you like to receive our funding reports for Manual Claim Reimbursements and Debit Card Settlement Funding?

Name

Email

Name

Email

Name

Email

I have reviewed the information provided herein and have verified that it is accurate and complete. As information changes, it is the responsibility of the employer to communicate the changes in a timely manner to Asure. Please be sure to return this signed document and other related plan enrollment materials at least **45** days prior to the desired renewal plan start date. For optimal enrollment numbers, please allow for a two-week open enrollment period for your current or prospective plan participants to enroll in this plan. FSA Participant Kits, will be provided to the employer via email within 10 business days upon receipt of this document.

Asure will email the employer a monthly invoice. The email will contain a link, which will contain the invoice. Payment must be made payable to Asure Employer Services by the invoice due date. A late fee will apply if payments are not received by the invoice due date.

COMPANY NAME: _____

SIGNATURE: _____

DATE: _____

PRINT NAME: _____

TITLE: _____