FSA - Implementation Check List

Please complete the following forms and return to clientservices@asibenefits.com or fax to 559.475.5787:

- ASi Universal Employer Application
- Set-up Forms
- Bancorp Authorization Form (for Benny Cards only)
- ASi ACH Form

Notes:

Administrative Solutions, Inc. (ASi)
P. O. Box 5809 | Fresno, CA 93755
Ph. 559.256.1320 | Fax 559.475.5787
clientservices@asibenefits.com | www.asibenefits.com

Section 125
Flexible Spending Account Plan
Set-up Form

Group Name:_____ **Total Employed:**_____

Effective Date: _____

Plan Year: _____ **Begins (mm/dd):** _____ **Ends (mm/dd):**_____

Is first year a short Plan Year? □ Yes □No
If yes, please provide: Start Date: _____ End Date:_____

Do you currently have an FSA in place with another vendor? □ Yes □No
If yes, will any of the following apply during the set-up process?
- Will ASi administer the run-out of your current plan? □ Yes □No
- Does your current plan allow for a $500 Rollover or 2 ½ month Grace Period? (Please circle one)

Is the Employer a member of the one of the following groups?
□ **Affiliated Service Group** □ **Controlled Group**
If yes, please list all members of the group:

_____

Plan Number: □ **501** □ **502** □ **503** □ **504** □ **505** □ **506**
(if none selected, one will be assigned)

Pay Periods

□**Weekly** □ **Bi Weekly** □ **Semi Monthly** □ **Monthly**

Plan Start Date	Plan End Date	First Payroll Date	Last Payroll Date	# of deductions per Plan Year

Plan Benefits

The employer is offering the following benefits under this plan (check all that apply):

☐ Premium Only Plan ☐ Medical FSA Benefits ☐ Dependent Care Benefits

☐ Limited FSA Benefits (HSA Compatible) ☐ Employer Funded FSA ☐ Simple FSA

Please indicate which Premium Only Plan Benefits will be offered pretax (check all that apply):

☐ Medical Insurance ☐ Dental Insurance ☐ Vision Insurance

☐ Disability Insurance ☐ Group Term Life Insurance ☐ HSA Contributions*

☐ Other: (Specify)_____

**If offering an HSA program, medical FSA expenses will be limited for those participating in the HSA to qualified dental, vision and OTC expenses. ASi will need to be made aware of the employees enrolled in the HSA.*

Members enrolled in any of the above contracted benefits will automatically be enrolled in the Premium Only Plan.

Plan Eligibility

□ The same day employee becomes eligible for contract(s), as described under Plan Benefits.
□ Other:_____

Minimum service requirement for an Eligible Employee to become eligible to be a Participant in the Plan:

□ None.
□ Completion of _____ hours of service □ Completion of _____ months of service
□ Completion of _____ days of service □ Completion of _____ years of service

Please indicate if any of the following employee classifications are going to be excluded from enrolling in the plan:

□ There are no exclusions; or
The following classes of employees are excluded (check all that apply):

□ Employees covered under a collective bargaining agreement (Union)
□ Leased employees
□ Nonresident aliens
□ Part-time employees (If checked, a part-time employee is an employee who works less than _____hours per week.
□ Other (specify):_____

Eligibility Requirements

Employee has been employed by the Employer for _____ consecutive calendar days and is regularly scheduled to work _____hours or more per week; or
_____Other (Specify):_____

Employees who first become eligible to participate in the plan mid-year may commence participation on:

____The first day of the month after eligibility requirement has been satisfied
____The first day of the following plan year

Employees who are terminated for any reason and are rehired within 30 days will be subject to eligibility requirements as a new hire: □ Yes □No

Employees who cease to be eligible for reasons other than termination such as reduction in hours or disability leave of absence and are reinstated to eligible status outside of 30 days:

____Must complete the stated waiting period in order to become eligible
____Do not need to complete the waiting period before becoming eligible

FMLA

Is this Plan subject to FMLA? □ No (1-49 employees) □ Yes (50+ employees)

Medical FSA Component

□ The **minimum** annual benefit amount that a participant may elect to receive for medical care expenses incurred in any plan year shall be:_____ (If left blank, the minimum will default to zero)

(Choose one of the below options)

□ The **maximum** annual benefit amount that a participant may elect to receive for medical care expenses incurred in any plan year shall be:_____
□ The **maximum** election amount allowed pursuant to IRS regulations. (Which may be updated annually.)
Note: The current maximum for 2019 is $2,700.00

Coverage for a participant who enters the Plan mid-year:

□ Will be allowed to elect the entire maximum annual benefit amount; or

□ Will be allowed to elect a pro-rated benefit amount based on the total months remaining in the Plan year.
Please note: It is an employer's choice to allow the full election amount or prorating of the full election amount for mid-year enrollments. ASi does not track the option selected, therefore we will enroll as indicated when the enrollment is sent to ASi

Run-Out

A participant who has elected to receive Medical FSA benefits for a plan year, may request reimbursement from the administrator no later than (please select one of the following):

□ 60 *or* □ 90 days following the earlier of either (a) the close of the plan year in which the expense was incurred or (b) the date of the employee's termination.

Grace-Period or Rollover

Would you also like to allow one of the following?

(a) a **Grace Period** of 2 ½ months (75-days) for the medical component (the Grace Period allows employees to incur new expenses within the 2 ½ month period)

□ Yes □ No

Run-out rules associated with the Grace Period:
If electing the Grace Period, the Plan will only allow for the 90 Day Run-out. The 90-day run-out will begin immediately after the end of the Plan Year. Therefore, the member will only have 15 days following the end of the 2 ½ month Grace Period to submit claims.

(b) a **Rollover** (the Rollover will roll any remaining balances up to **$500** into the next Plan Year)

□ Yes $_____ □ No

➔ If you have elected the rollover option, please select one of the below options (please only select one):

□ Only participants with new Plan Year elections can rollover funds; or

□ Rollover funds are available for all participants regardless of an active election for the new Plan Year. *

Please note that administrative fees apply for the entire Plan Year, for all active elections, including those who only have rollover funds and regardless of their account balance.

Substantiation of Claims Process

☐ Claims to be substantiated according to ASi's process of substantiation. (IRS Requirement)

☐ We choose to opt out of claims substantiation and release ASi and their system vendor of any requirements set by the IRS.

* If opting out of substantiation of claims, ASi will send you a hold harmless agreement for signature.

Dependent Care Component

The **maximum** annual benefit amount that a participant may elect to receive for dependent care expenses incurred in any plan year shall be $2500 if the employee is married but filing separately and $5000 if the employee is married and filing a joint return or is a single parent.

Run-Out

A participant who has elected to receive Dependent Care benefits for a plan year, may request reimbursement from the administrator no later than (please select one of the following):

□ 60 *or* □ 90 days following the earlier of either (a) the close of the plan year in which the expense was incurred or (b) the date of the employee's termination.

Would you like to allow for the **Grace Period** of 2 ½ months (75-days) for the DCAP component?

□ Yes □ No

Run-out rules associated with the Grace Period:

If electing the Grace Period, the Plan will only allow for the 90 Day Run-out. The 90-day run-out will begin immediately after the end of the Plan Year. Therefore, the member will only have 15 days following the end of the 2 ½ month Grace Period to submit claims.

Plan Funding

Please select from one of the below funding options:

☐ **Debit Card Funding**

Deposit options:

□ Weekly replenishment – 5% deposit of the aggregate participant annual election amount.

□ Daily replenishment – 3% deposit of the aggregate participant annual election amount.

- **Please complete the Bancorp ACH form (this is the account that will be linked to the debit cards).**
- **Please complete the ASi ACH form (this is for any manual claims that may be submitted).**
- **Debit cards will require a 3% or 5% deposit of the aggregate participant annual election amount. Deposit must be processed prior to debit cards being issued.**
- **Debit card security deposit will be refunded after 120 days of the Plan termination**
- **Debit cards are valid for three years from the issue date. Cards are not reissued for new elections if the participants' cards are still valid. If a new card is requested, a fee will be incurred for the new cards.**

☐ **Non-Debit Card Funding**

- **ACH for Claims** ASi will debit your account for claim utilization on a weekly basis, as applicable. (ASi ACH authorization form must be completed.)

Funding Notification Contact – (if different from the contact on our Universal Application**)**

Contact Name:_____ Email:_____ Phone:_____

Contact Name:_____ Email:_____ Phone:_____

Please select from one of the following options on how your company would prefer to receive the monthly invoices for administrative fees: ☐ U.S. Mail ☐ E-Mail

Please provide the e-mail address if different than what is listed on the Universal Application: _____

Client Check List and Information: (ASi will need all forms to complete your plan set up)

- **ASi Universal Employer Application –** this captures the demographic information regarding your group
- **FSA Set-Up Form –** this captures the set-up information for your plan
- **Bancorp Authorization Form (if utilizing a debit card) –** this allows VISA to ACH your bank account for transactions
- **ASi ACH Authorization Form –** this allows ASi to ACH your account for manual claims
- **Employee Enrollments –** to enroll members on the benefit plan

Certification of Accuracy

I certify that the information provided on this form is accurate to the best of my knowledge. I understand that ASi will utilize this information for preparation of our Plan Documents.

Completed By: _____ **Title:** _____

Signature:_____ **Date:** _____

Once ASI receives all the information on the set up of the group, we will send a welcome kit out to the group contact. This will include forms to utilize during the year, administrative agreement, department contact list and the plan document if ASI prepares it.

Payment Solutions
The Bancorp Bank
America's Leading Private-Label Banking Resource

MEMBER FDIC
Banking Services Provided by The Bancorp Bank

The Bancorp Bank Payment Solutions Group

AUTHORIZATION FOR ACH DEBITS / CREDITS

_____

Depositor Name as Shown on Bank Records

_____

Checking Account Number / Transit Routing Number
*(A voided check or spec sheet **must** be attached for this account)*

TO: _____

_____
(Bank Address: Street, Box #, City, State and Zip Code)

Depositor authorizes The Bancorp Bank to present automated debits and credits to and from the above listed account as required to perform their responsibilities related to processing Depositor's benefit program. This authorization will remain in effect until revoked by Depositor in writing and until you actually receive such notice Depositor agrees that you shall be fully protected in honoring any such ACH transaction.

Depositor agrees that your treatment of each such ACH transaction and your rights in respect to it shall be the same as if it were a check signed by Depositor.

I authorize payments to be withdrawn daily or weekly as needed.

Dated this _____ day of _____, 20_____.

_____

Signature of Depositor in Agreement with Bank Records

Please update your ACH filter (on the above reference account) to grant access to The Bancorp Bank. The Bancorp Bank identification number is: **1050006509**.

Administrative Solutions, Inc.
Authorization for Electronic Funds Transfer

Company Name: _____

Financial Contact Name: _____ ___

Financial Contact Email: _____

Type of Service(s): _____

Please debit my account for:

- ☐ Claims
- ☐ Contributions
- ☐ Fees
- ☐ Premiums

I hereby authorize Administrative Solutions, Inc. to initiate variable debit entries to my __ checking account or __ savings account indicated below and my financial institution named below to debit the same to such account.

Account Number: _____

Financial Institution: _____

Branch:_____ **City:**_____ _____ **State :**_____

Bank Routing Number: _____

This authority will remain in full force and effect until Administrative Solutions, Inc. has received written notification from me of its termination in such time and in such manner as to afford Administrative Solutions, Inc. a reasonable opportunity to act on it.

Signature _____ **Date** _____

An actual *voided check* must be attached

Staple voided check here

If an actual check is not available to attach (i.e. some savings accounts), you are responsible for obtaining the correct routing number from your financial institution.

Administrative Solutions, Inc.
P. O. Box 5809, Fresno, CA 93755
Ph. (559) 256-1320 / Fax (559) 475-5787
clientservices@asibenefits.com