



San Francisco HCSO Compliance Set-Up Form

Client Name: _____

ASi Effective Date: _____ First Reporting Period: _____

(Large: 100+ employees) (Medium: 20-99 employees)

Is this Plan subject to FMLA?

No (1-49 employees) Yes (50+ employees)

Benefit Design

Excepted Benefits Plan:

This Plan will allow for eligible out-of-pocket dental/vision expenses and other excepted benefits allowed by Federal Reg. 54.9831-1.

Special Instructions:

Integrated Health Reimbursement Arrangement (HRA):

This Plan will be set-up for participants enrolled in a group medical plan, which may require an additional contribution per the HCSO spend requirement.

Please select from the following on what expenses will be allowed for reimbursement under this Plan:

Medical Dental Vision Prescription Chiropractic Acupuncture All Eligible Expenses under IRC 213(d)
 Other (Include schedule of available expenses) Expenses tied to carrier deductible (Carrier: _____)

Special Instructions:

Take-over Plans

Will ASi administer the run-out plans for contributions made prior to 2019? Yes No

Type of Expenditure

Irrevocable Expenditure

An Irrevocable Health Care Expenditure is an expenditure that cannot be retained or recovered by the employer. Therefore, once an irrevocable expenditure has been made on behalf of a covered employee, the funds, even if unused, can never be recovered by the employer. This also applies to employees who separate employment with their employer and/or if the business ceases to operate.

Mailing Quarterly Statements:

Would you like for ASi to mail the employees' quarterly statements that are required to be provided to your participants? If yes, there will be an additional fee of \$1 (per participant, per quarter).

Yes No

Emailing Invoices:

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

Banking Instructions

ASi will open a separate account for the benefit of the client and the irrevocable funding will be held in that account. We will then use the irrevocable funds to pay the members' claims.

PLEASE NOTE: Reimbursement checks will not be released to the employee(s) until adequate funding is received by the employer.

Authorized Signature: _____ **Print Name:** _____

Title: _____ **Date:** _____

ASi Internal Use

Implementation Fees: _____
Per Participant/Per Month: _____
Employee Statements: _____
Other: _____