Diversified Administration, Inc.
Tax Savings For Employers & Employees

FSA/HRA Data Gathering Form

EMPLOYER INFORMATION

_____
Legal Name of Employer

_____
Address

_____
City, State, Zip

_____
Employer Tax I.D. Number

_____
Date Incorporated

_____
Operating Pursuant to the State Laws of

_____
Nature of the Business

_____
Web page

Total number of Employees: _____

Total number of Participants: _____

Primary Human Resources Contact Information

_____
Name

_____
Title

_____
Telephone Number + Extension

_____
E-mail

_____
Fax Number

Corporate Officer
(Authorized to act on behalf of Employer):

_____

Billing Address (if different than Employer address)

_____

_____

Organization Type:

- ❑ Corporation.
- ❑ Professional Corporation
- ❑ Partnership
- ❑ Government Agency
- ❑ Other _____
- ❑ Sub-chapter "S" Corporation
- ❑ Professional Association
- ❑ Sole Proprietorship
- ❑ LLC Limited Liability Company

NOTE: Only employees can participate in a Cafeteria Plan. Thus, while partnerships, sole proprietorships and Sub-chapter "S" corporations may sponsor Cafeteria Plans, the following cannot participate: sole proprietors, partners, and greater than 2% shareholders in Sub-chapter "S" corporations, LLC or LLP members.

Does this Employer already offer an active FSA/HRA plan? ❑ Yes ❑ No

For Mergers & Acquisitions Only –

Is there another Section 125 plan which is hereby amended or restated into this plan? ❑ Yes ❑ No

If "yes", state the Name of Prior Plan Sponsor: _____

Original Effective Date of the Plan: _____

Will an Affiliated Employer adopt the Plan? ❑ Yes ❑ No

If "Yes" please provide the employer name, address, phone, federal tax id number and corporate structure below:

_____ _____
Legal Name of Affiliated Employer Employer Tax I.D. Number

_____ _____
Address City, State, Zip

_____
Phone

Organization Type:
- ❑ Corporation.
- ❑ Sub-chapter "S" Corporation
- ❑ Professional Corporation
- ❑ Professional Association
- ❑ Partnership
- ❑ Sole Proprietorship
- ❑ Government Agency
- ❑ LLC Limited Liability Company
- ❑ Other _____

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Does this Employer already offer an active FSA/HRA plan? ❑ Yes ❑ No

FSA Implementation

FSA Plan Year	
Original Effective Date:	____/____/____
Plan Year Runs:	___/____ to ___/____ (Only Enter MM/YY)
Current Plan Year Begins:	____/____/____
Current Plan Year Ends:	____/____/____

EXTENSION PERIOD

(Note: For the Medical FSA, you may choose either the Extension Period or the Rollover, but not both).
Expenses for qualified benefits incurred during the period of time not to exceed 2 months and 15 days following the end of the preceding Plan Year may be reimbursed from benefits or contributions remaining unused at the end of the immediately preceding Plan Year.

Yes	No	
❑	❑	Medical FSA
❑	❑	Dependent Daycare FSA

ROLLOVER

Participants may rollover up to $500 of unused funds from the Medical FSA remaining at the end of the Plan Year to the immediately following Plan Year.

❑ Yes ❑ No

BENEFITS

A. The following will be offered as pre-tax benefits covered under this plan;

- ❑ Core Health Benefits
- ❑ Non-Core Supplemental Health Benefits
- ❑ Dental
- ❑ Short Term Disability Benefits
- ❑ Long Term Disability Benefits
- ❑ Group Term Life Benefits
- ❑ AD&D
- ❑ Vision
- ❑ Health FSA
- ❑ Dependent Care FSA
- ❑ Hospital Indemnity Insurance
- ❑ Cancer Coverage
- ❑ Dread Disease & Catastrophic Illness
- ❑ _____

B. Expense Reimbursement Accounts

❑ **Dependent Care Reimbursement Accounts**
Maximum permissible reimbursement per participant annually $_____(normally $5,000).

- Any special participation requirements which apply only to the Dependent Care Reimbursement Accounts should be indicated below:

_____

❑ **Medical (including dental) Expense Reimbursement Accounts**
Maximum permissible reimbursement per participant annually $_____

- Any special participation requirements which apply only to the Medical (including dental) Expense Reimbursement Accounts should be indicated below:

_____

C. ❑ Health Savings Account (not part of this plan; however, the participants may make pretax contributions into this account on a payroll deduction basis).

Employees contributing to an HSA account can also participate in a Limited Purpose FSA plan which will only reimburse Dental and Vision expenses until an IRS Statutory Deductible has been met (Check the regulations for current limits).

❑ **Limited Purpose FSA Expense Reimbursement Accounts**

Maximum permissible reimbursement per participant annually $_____

- Any special participation requirements which apply only to the Medical (including dental) Expense Reimbursement Accounts should be indicated below:

_____

D. The maximum amount which a Participant may elect in Salary Reduction Benefit Dollars and Participant After-Tax Dollars is the amount established by the employer for the year, or $20,000 if the Employer does not establish such an amount.

E. Flexible Benefit Dollars shall consist of: (check as appropriate)

- ❑ Employer Non-Discretionary Benefit Dollars-
- ❑ Employer Discretionary Benefit Dollars –
- ❑ Salary Reduction Benefit Dollars (Most commonly used)
- ❑ Participant After-Tax Benefit Dollars

F. Compensation paid by the Employer to the Employee/Participant in any plan year can consist of;

- ❑ bonus payments
- ❑ Overtime payments
- ❑ Commissions
- ❑ Severance pay
- ❑ Other: specify_____

PARTICIPATION REQUIREMENTS

Employees of the Employer shall be eligible to participate in the plan upon: (Check all that apply)

- ❑ (A) The attainment of ___ years of age (generally 21)
- ❑ (B) The first of the month following _____days of regular fulltime employment
- ❑ (C) Full-time employment shall be defined as _____hours per week or more on a regular basis
- ❑ Other: specify_____

DEDUCTION & REIMBURSEMENT INFORMATION

Are all the employees paid on the same schedule? ❑ Yes ❑ No

The employees are paid as following: (Enter as many frequencies as are needed.)

- ❑ Weekly
- ❑ Biweekly
- ❑ Semi-Monthly _____(Deduction Dates/Days?)
- ❑ Monthly
- ❑ Other: specify_____

First pay date after effective date with Diversified:_____

Claims Reimbursement Options

We offer the following claims reimbursement options. You can make one or more options mandatory if you'd like, and you can also combine reimbursement methods; please check all options you would like to offer.

- ❑ Reimbursement by paper check
- ❑ Reimbursement by ACH/EFT Direct Deposit
- ❑ Reimbursement by Payment report sent to HR – HR then processes reimbursement internally
- ❑ FSA/HRA Debit Card (Debit Card can be utilized with any or all of the above reimbursement methods)
  - o If you are interested in offering the FSA/HRA linked MySource Debit Card, please Hold the CTRL key and then Click Here to open the Debit Card Agreement Package in Adobe Reader. Please contact Ann@div125.com if you have questions about setting up Debit Card accounts.
  - o Special rules apply to debit card and HRA. Please contact us for details.

HRA Implementation

HRA Plan Year – Note for an HRA linked to your medical plan, the plan year will be your Deductible Plan Year and not necessarily your plan renewal date,	
Original Effective Date:	____/____/____
Plan Year Runs:	___/____ to ___/____ (Only Enter MM/YY)
Current Plan Year Begins:	____/____/____
Current Plan Year Ends:	____/____/____

Please select the type of HRA plan you would like to implement

❑ HRA Linked to your Medical Insurance Plan

❑ Non-Linked HRA – Dental and Vision expenses ONLY

- ❑ Carry-Over Option – Carry over _____($/%) in unused funds into subsequent plan years

Plan Design:

Linked HRA –

For Employee Only Coverage

Plan Pays $_____of the $_____ deductible

After Participant incurs the first $_____ of the deductible

Plan Pays _____% of the Medical Insurance

- ❑ Deductible
- ❑ Co-Pays
- ❑ Co-Insurance

For Employee + Dependent(s) Coverage

Plan Pays $_____of the $_____ deductible

After Participant incurs the first $_____ of the deductible

Plan Pays _____% of the Medical Insurance

- ❑ Deductible
- ❑ Co-Pays
- ❑ Co-Insurance

Additional Notes

_____

_____

Non-Linked HRA –

Plan pays for dental and vision expenses as follows

_____

_____

Required Substantiation

Requests for reimbursement must be accompanied with proper substantiation as set forth below. The claims may be denied if this substantiation is not provided.

Substantiation for Linked HRAs consists of Explanation of Benefits (EOB) Form(s) from the linked insurance policy indicating the amount(s) that you are obligated to pay.

Substantiation for non-Linked HRAs consists of Receipt/Statement from the provider/an independent third party stating the day the services were incurred, the name of the person incurring the service, and the amount of the services.

Employer Check & Direst Deposit Authorization Form

Company Name: _____ authorizes Plan Service Provider (Diversified Administration, Inc.) to originate credit/debit entries to and from the below named account through the EFT Services provided by DataPath Administrative Services, Inc. (DPAS).

This authorization allows Diversified Administration to process reimbursements for our company plan participants by the following method(s) from the bank account listed below;

- ❑ Paper Checks
- ❑ Direct Deposit

Name of Bank: _____

Bank Address: _____

Bank City: _____ Bank State:_____ Bank Zip Code:_____

Name on Account: _____

Account Number: _____

Bank Routing No. (MICR) (Ex: 123456789): _____

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

Person Signing Check: _____

Type of Account:

- ❑ **Checking**
- ❑ **Savings**

Effective Date: _____

Title: _____
Printed Name: _____
Date Signed: _____
Signature: _____

Secondary Benefit Coordinator (if applicable)

The Benefit Coordinator is the individual at the Employer to whom Employees should direct communications and inquiries.

Name: _____

Title: _____

Telephone _____ Alternate Phone:_____

E-mail _____ Website:_____

Tertiary Benefit Coordinator (if applicable)

The Benefit Coordinator is the individual at the Employer to whom Employees should direct communications and inquiries.

Name: _____

Title: _____

Telephone _____ Alternate Phone:_____

E-mail _____ Website:_____

IMPORTANT:
THE DEPARTMENT OF LABOR REQUIRES ALL WELFARE PLANS TO HAVE A SUMMARY PLAN DESCRIPTION. IF YOU DO NOT HAVE A CURRENT, UPDATED WELFARE SPD AND YOU WOULD LIKE DIVERSIFIED ADMINISTRATION TO ASSIST YOU WITH THIS, PLEASE INDICATE BELOW:

❑ **YES** ❑ **NO**