ProBenefits
The benefit of trust.

Master Application

Requested Services	
☐ POP (Section 125 Premium Only Plan) ☐ FSA (Section 125 with FSAs) ☐ HRA (Health Reimbursement Accounts) ☐ HSA (Health Savings Accounts) ☐ Transit and/or Parking Accounts	☐ COBRA Administration ☐ 5500 Service ☐ Wrap SPD Service
Effective Date(s) of service(s):	

Employer Information		
Company Legal Name:		
DBA:		
Mailing Address:		
Physical Address:		**Suite:**
City:	**State:**	**Zip:**
Phone:	**Fax:**	
Federal Tax ID:		
List of Affiliated Entities:		
Type of Organization: (Select one) ☐ S-Corp ☐ Proprietorship ☐ Partnership ☐ LLC taxed as _____ ☐ C-Corp ☐ Government ☐ Non-Profit ☐ Other: _____		

Employer Administrator Contacts		
Primary Contact		
First Name:	**Last Name:**	
Title:	**Phone:**	**Ext:**
Email:	**Fax:**	
Additional Contact		
First Name:	**Last Name:**	
Title:	**Phone:**	**Ext:**
Email:	**Fax:**	

Benefit Broker / Consultant Information		
Name of Agency/Firm:		
First Name:	**Last Name:**	
Email:	**Phone:**	**Ext:**
Mailing Address:		
City:	**State:**	**Zip:**
Account Manager		
First Name:	**Last Name:**	
Title:	**Phone:**	**Ext:**
Email:	**Fax:**	

Benefit Eligibility

Hours per week	Waiting Period	Plan Entry Date	Coverage end date
☐ 30 hours ☐ Other: _____	☐ 30 days ☐ Other: _____	☐ Immediate ☐ 1st of the following month	☐ Date of termination ☐ End of month

Number of Benefit Eligible Employees:

Benefit Information

Benefit Type	Renewal Date Example: 7/1	Pre-Tax	Post-Tax	ER Paid
Medical	_____			
Dental	_____			
Vision	_____			
Group Term Life	_____			
Short-Term Disability	_____			
Long-Term Disability	_____			
Cancer	_____			
AD&D	_____			
HSA Contributions	_____			
Other: _____	_____			
Other: _____	_____			
Employer Benefit Credit				

Payroll Information

Date of 1st Employee Payroll Contribution:

Payroll Schedule

☐ Weekly
☐ Bi-Weekly*
- ☐ 24 pay periods
- ☐ 26 pay periods

☐ Semi-monthly
- ☐ 1st and 15th
- ☐ 15th and last

☐ Monthly
☐ Other: _____

**If Bi-Weekly, please confirm if you would like 24 or 26 payroll contributions.*

Benefit Administration/Payroll System Information and Integration

Are you using a Benefit Admin./Payroll System? ☐ **Yes** ☐ **No**

If yes, name of Company/System you are using:_____

Will ProBenefits have access to the data in the Benefit Admin./Payroll System? ☐ **Yes** ☐ **No**

If yes, what type of data? Check all that apply:

☐ **Open Enrollment Elections**
☐ **New Hires/Terminations**
☐ **Mid-year Election Changes**
☐ **Employer Demographics**
☐ **Employee Demographics**
☐ **Group Benefit Rates**

Discrimination Testing

As part of the administration of your company's plan, ProBenefits analyzes and, if necessary, conducts certain discrimination testing in accordance with IRS regulations. The data below is used to help determine the number of key employees, and whether more detailed information is needed to conduct testing. The information requested below is critical for this analysis. If you need additional space, feel free to attach a separate chart.

Name of Owner or Officer	Officer>$175K (1)	>5% Owner (2)	>1% Owner with >$150K (3)	Pre-taxing Premiums?
Example: John A. Smith	**Yes**	**No**	**Yes**	**Yes**

Key Employees

(1) Officers** with compensation* more than $175,000 (during prior year);

(2) Individuals who are more-than-5% owners of the employer; or

(3) Individuals who are more-than-1% owners of the employer with compensation* more than $150,000.

* Compensation under this definition includes annual gross salary and wages paid by employer to employee

** Officers are determined based on duties, not titles.

Stock Attribution:

Per IRS regulations, under certain circumstances employee spouses of Key Employees or Highly Compensated Employees may be considered Key or Highly Compensated, by attribution of stock ownership or by special IRS rule. Depending on circumstances, the attribution rules may apply also to parents, children, grandparents, or grandchildren. If you have employee spouses or dependents of HCEs or Keys participating in the plan, please make sure to let your ProBenefits administrator know so that this issue can be addressed.

Testing Exemptions:

A plan that has no key employees is exempt from discrimination testing.

Discrimination testing of benefit plans administered by ProBenefits assumes equal treatment of all benefit-eligible employees as to (1) eligibility to participate and (2) contribution and benefits provided by the employer. If your company does not treat all benefit-eligible employees equally, your plan may be outside of IRS compliance requirements.

FSA (Flexible Spending Account) Administration

Plan Start Date:	**Plan End Date:**

FSA Options: (select all that apply)

☐ **Medical FSA** – All 213(d) expenses (Medical, Dental, Vision)
☐ **Limited Purpose FSA** – Dental and Vision expenses only
☐ **DCAP FSA** – Work related child-care expenses for dependent children ages 12 or under

Medical FSA Election Maximum: ☐ **$2700 (IRS Maximum)** ☐ **Other: $ _____**
Annual Maximum must be prorated for Short Plan Years

Medical FSA Election Minimum: ☐ **Other: $ _____** ☐ **No Minimum**

Will there be Employer Contributions to the Medical FSA? ☐ **Yes** ☐ **No**
Employer FSA contributions are limited to $500 or a dollar for dollar match of employee contributions

If yes: ☐ **$500** ☐ **Other: $ _____**

Medical FSA Carryover: ☐ **Yes** ☐ **No**
At the end of plan year a participant can carryover up to $500 of any unused funds into the new plan year

Medical FSA Grace Period: ☐ **Yes** ☐ **No**
2 ½ month period after the plan year ends, when participants can spend down any unused balance

An FSA plan cannot have both a Grace Period and Carryover. A plan can only offer one or the other. Either option applies to the Medical FSA – not the DCAP FSA.

DCAP FSA Election Maximum: ☐ **$5000 (IRS Max. per household)** ☐ **Other: $ _____**

DCAP FSA Election Minimum: ☐ **$ _____** ☐ **No Minimum**

FSA Payment Options: *(Check all that apply. We recommend Debit Cards and Direct Deposit Only)*

☐ **Debit Cards** *(Medical FSA only)*
☐ **Direct Deposit** *(Paper claims received by Friday; released the following Wednesday for Direct Deposit)*
☐ **Monthly Checks** *(Paper claims received by the 5th of the month; Checks mailed on the 15th of the month)*
☐ **Payment Register Only** *(ProBenefits emails payment register; Employer makes payment to employees)*

Debit Card Auto-Substantiation Information:
The IRS allows auto-substantiation of certain debit card transactions. To maximize our ability to auto-substantiate, please include a copy of the Benefit Summaries for all group health plan options.

Take-Over Information

Is there an existing FSA plan already in place with another administrator? ☐ **Yes** ☐ **No**

If yes, provide previous FSA administrator's name: _____

If yes, will previous administrator handle the claims run-out period? ☐ **Yes** ☐ **No**
(If no, additional fees will apply for ProBenefits to handle the claims run-out period of existing plan)

HRA (Health Reimbursement Arrangement) Administration

Plan Start Date:	**Plan End Date:**

Linked Health Plan Renewal Date:

Linked Health Plan Deductible/Out-of-Pocket Maximum Renewal:

☐ **Calendar Year** ☐ **Plan Year**

Linked Health Plan Deductible/Out-of-Pocket Maximum Tracking:

☐ **Aggregate** – entire family deductible/out-of-pocket maximum is met by one or more covered persons

☐ **Embedded** – any one covered person must only meet the employee only deductible/out-of-pocket

(Please include a copy of the Summary of Benefits for the linked health plan along with this application)

HRA Eligible Expenses: **In-network Only?** ☐ **Yes** ☐ **No**

☐ **All IRS 213(d) Eligible Expenses** (Medical, Dental, Vision)
☐ **Expenses applied to Deductible and/or Coinsurance of linked Health Plan**
☐ **Expenses applied to Out-of-Pocket Maximum of linked Health Plan**
☐ **Copays of linked Health Plan**
☐ **Dental Only Expenses**
☐ **Vision Only Expenses**
☐ **Other:** _____

New Hire Benefit: ☐ **Annualized** ☐ **Pro-Rated Monthly**

Dependents Covered: ☐ **Yes** ☐ **No**

HRA Plan Tracking: ☐ **Aggregate** ☐ **Embedded**

HRA Plan Design Description:
(Please write a brief description of the HRA plan design which includes the amount and/or portion the covered participants and HRA pays for each eligible expense). Attach separate page if necessary.

HRA Payment Options: *(Check all that apply)*
☐ **Debit Cards** *(Option only for All IRS 213(d) HRA plans or RX only expenses)*
☐ **Direct Deposit** *(Paper claims received by Friday; paid the following Wednesday by Direct Deposit)*
☐ **Monthly Checks** *(Paper claims received by the 5th of the month; Checks mailed on the 15th of the month)*
☐ **Payment Register Only** *(ProBenefits emails payment register; Employer makes payment to employees)*

Take Over Information

Is there an existing HRA plan already in place with another administrator? ☐ **Yes** ☐ **No**

If yes, provide previous HRA administrator's name: _____

If yes, will previous administrator handle the claims run-out period? ☐ **Yes** ☐ **No**
(If no, additional fees will apply for ProBenefits to handle the claims run-out period of existing plan)

COBRA Administration

Number of Employees enrolled in COBRA eligible benefit plans: _____

Number of current COBRA participants: _____

Number within the COBRA election window: _____

Name of current COBRA administrator: _____

Have COBRA initial Notices been sent to all covered employees and dependents?

☐ **Yes** ☐ **No**

(If no, ProBenefits can send new Initial Notices to all covered persons. Fee is $3/per mailed notice. Check box here if you would like for ProBenefits to provide this service: ☐

HSA (Health Savings Account) Administration

Qualified High Deductible Health Plan Information:

Employee Only Deductible: $ _____ Family Deductible: $ _____

Renewal Date: _____

Employer Pays Admin. Fee: ☐ **Yes** ☐ **No**

Will there be Employer Contributions to HSA? ☐ **Yes** ☐ **No**

If yes: ☐ **Monthly** ☐ **Annual** ☐ **Other _____**

Total Annual Amount of Employer Contribution per Employee: $_____

Transit and Parking Plan Administration

Plan Start Date:	**Plan End Date:**

Transit Plan monthly maximum: ☐ **$265 (IRS Maximum)** ☐ **Other: $ _____**

Parking Plan monthly maximum: ☐ **$265 (IRS Maximum)** ☐ **Other: $ _____**

Will there be Employer Contributions to the Plan? ☐ **Yes** ☐ **No**

If yes, enter amount of Employer Contribution to each employee account per month:

Transit: $ _____ Parking: $ _____

Will post-tax contributions be allowed? ☐ **Yes** ☐ **No**