ALL NEW CLIENTS MUST COMPLETE THIS PAGE.

▶ NEW CLIENT APPLICATION **SECTION 1**

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Please check the applicable service(s) requested:

- ☐ Medical Flexible Spending Account (MFSA)*—complete sections **1–4**
- ☐ Limited Purpose FSA (LPFSA)*—complete sections **1–4**
- ☐ Dependent Care Flexible Spending Account (DCFSA)*—complete sections **1–4**
- ☐ Healthcare Reimbursement Account (HRA)*—complete sections **1–4**
- ☐ Health Savings Account (HSA)*—complete sections **1–2**
- ☐ Commuter Reimbursement Account (CRA)*—complete sections **1–4**
- ☐ VEBA/HRA Administration (VEBA)*—complete sections **1–4**
- ☐ COBRA Administration (COBRA)—complete sections **1, 3, 4,** and **5**
- ☐ Premium-Only Plan (POP)**—complete sections **1–3**
- ☐ Document Only (No Administration)

*includes the AmeriFlex Convenience Card® **Clients looking for POP plans only please visit the AmeriFlex ePOP site www.epopdocs.com

SAVE PRINT EMAIL RESET

Please mail, fax, or e-mail all forms to:

AmeriFlex
302 Fellowship, Suite 100
Mount Laurel, NJ 08054
Attn: Account Implementation Department
Phone: 888.868.FLEX (3539) Fax: 888.506.6392

AmeriFlex Convenience

Date Received by AmeriFlex

Employer Information (This section must be completed for all services selected.):

Legal name of employer: _____

Telephone: _____ Fax: _____

Employer mailing address: _____

City: _____ State: _____ Zip: _____

Contact person for monthly invoicing: _____ E-mail address: _____

Contact person for monthly administration: _____ E-mail address: _____

State of legal construction: _____ Federal Tax ID #: _____ Type of legal entity (Corp., Sole Prop., Partnership, etc.): _____

Sub-Chapter "S" Corp.? YES ☐ NO ☐

Are affiliated employers adopting this plan? YES ☐ NO ☐ (If YES, please complete the Affiliated Employer Worksheet.)

Number of benefit-eligible employees: _____ Number of insured employees _____ Total number of employees: _____

Fees and Administration (This section must be completed for all services selected.):

Medical/Dependent Care Flexible Spending Accounts ☐ **Limited Purpose FSA** ☐ **VEBA/HRA Administration** ☐

One-time account setup: $_____ Monthly Administration (per participant/per month): $_____ Annual Renewal: $_____

Health Reimbursement Accounts **Health Savings Accounts** Note: HSA Monthly Administration Fee excludes any applicable investment account charges (charged to participant)

One-time account setup: $_____ Monthly Administration (per participant/per month): $_____

COBRA Administration:

One-time account setup: $_____ Monthly Administration (per participant/per month): $_____ Optional Initial Notification Letters for active participants: $5.00 each

Agent Information (This section must be completed for all services selected.):

Agent: _____

Enrollment Contact: _____

Address: _____

City: _____ State: _____ Zip: _____ Tel: _____

Fax: _____ E-mail: _____ Tax ID#: _____

Referred to AmeriFlex by: _____

Special notes/mailing instructions: _____

E-Mail completed documents to (if this line is left blank, documents will be sent to the client): _____ E-mail address: _____

Direct invoice to the attention of: _____ E-mail address: _____

FSA, HRA, HSA, CRA, VEBA AND POP APPLICANTS MUST COMPLETE THIS SECTION

▶ NEW CLIENT APPLICATION **SECTION 2**

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A. Cafeteria Plan Information (please complete for MFSA, DCFSA, LPFSA and POP components):

Premium Only Component (only fill in this section if you would like this information to appear in the cafeteria plan document and you have checked off the POP box on page one of the NCA):

New Plan: Plan year start:_____ Plan year end:_____ Is this a short plan year? YES ☐ NO ☐ If yes, next plan year must be a full 12 month plan.
Next plan year start:_____ End:_____ Original effective date:_____

Eligibility waiting period (check one): Days_____ Weeks_____ Months_____ Years_____ (**Waiting period must be uniform for all participants)
Date of eligibility (e.g. first of the month following, etc.):_____
Required working hours per week:_____ Are union employees eligible for participation ?_____
Core Benefits offered on a pre-tax basis:
Health ☐ Vision ☐ Dental Group ☐ Term Life ☐ Disability ☐ Cancer ☐ Accident ☐ Hospital Income ☐ Medical Gap ☐ Critical Illness ☐ Other ☐
If dental is offered, does it include orthodontia? YES ☐ NO ☐
If health insurance is offered, is it a PPO, HMO, POS, Indemnity?_____

HSA Component
If an HSA is offered, is it offered on a pre-tax basis? YES ☐ NO ☐ If yes, how is the HSA funded? Solely employee pre-tax contributions ☐ Employee and employer contributions ☐

Medical FSA and Limited Purpose FSA Component

New Plan: Plan year start:_____ Plan year end:_____ Is this a short plan year? YES ☐ NO ☐ If yes, next plan year must be a full 12 month plan.
Next plan year start:_____ End:_____

Takeover Plan: Original effective date:_____ Plan year start:_____ Plan year end:_____
Is this a mid-plan year takeover?_____ Number of existing participants:_____

Date of first pre-tax withholding for the Medical FSA Plan:_____
Eligibility waiting period (check one): Days_____ Weeks_____ Months_____ Years_____ (**Waiting period must be uniform for all participants)
Date of eligibility (e.g. first of the month following, etc.):_____
Required working hours per week:_____ Number of pays per year:_____ Number of withholdings per year:_____ Dates to skip:_____
Are union employees eligible for participation?_____ Will employee elections be supplied to AmeriFlex electronically?_____
Annual maximum for MFSA Plan:_____ Annual Maximum for LPFSA Plan:_____
What will the MFSA cover? All Code §213(d) expenses including dental and vision ☐ Dental expenses ☐ Vision expenses ☐ Other ☐
Will this plan include the 2.5 month extension? YES ☐ NO ☐
Run-out period (if no selection is indicated, the default is 3 months): Months_____
Please select your preferred orthodontia reimbursement method (if no selection is indicated, the default method is as incurred and paid):
As incurred and paid (i.e., month by month) ☐ As paid only (i.e., in advance of services rendered, regardless of amount) ☐
Would you like employees who are called to active military service mid-plan year to be allowed to cash out their unused balance? YES ☐ NO ☐

Dependent Care FSA Component

New Plan: Plan year start:_____ Plan year end:_____ Is this a short plan year? YES ☐ NO ☐ If yes, next plan year must be a full 12 month plan.
Next plan year start:_____ End:_____

Takeover Plan: Original effective date:_____ Plan year start:_____ Plan year end:_____
Is this a mid-plan year takeover?_____ Number of existing participants:_____

Date of first pre-tax withholding for the Dependent Care FSA Plan:_____
Eligibility waiting period (check one): Days_____ Weeks_____ Months_____ Years_____ (**Waiting period must be uniform for all participants)
Date of eligibility (e.g., first of the month following, etc.):_____
Required working hours per week: Number of pays per year:_____ Number of withholdings per year:_____ Dates to skip:_____
Are union employees eligible for participation?_____ Will employee elections be supplied to AmeriFlex electronically?_____
Annual maximum for DCFSA Plan (IRS Maximum is $5,000/family/year):_____
Will this plan include the 2.5 month extension? YES ☐ NO ☐ Run-out period (if no selection is indicated, the default is 3 months):_____ Months

PLEASE NOTE: Please review the above information carefully before submission. Once the new client application is submitted and plan documents are generated and sent, all changes will require an amendment fee even if the plan year has not started.

FSA, HRA, HSA, CRA, VEBA AND POP APPLICANTS MUST COMPLETE THIS SECTION

▶ NEW CLIENT APPLICATION SECTION 2

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B. Healthcare Reimbursement Arrangement:

New Plan: Plan year start: _____ Plan year end: _____ Is this a short plan year? YES ☐ NO ☐ If yes, next plan year must be a full 12 month plan.
Next plan year start: _____ End: _____ Original effective date: _____

Takeover Plan: Original effective date: _____ Plan year start: _____ Plan year end: _____
Is this a mid-plan year takeover? _____ Number of existing participants: _____

Eligibility waiting period (check one): Days _____ Weeks _____ Months _____ Years _____ (**Waiting period must be uniform for all participants)
Date of eligibility (e.g. first of the month following, etc.): _____
Required working hours per week: _____ Number of pays per year: _____
Does the employee have to be enrolled in the employer's High Deductible Health Coverage (HDHC) Plan to be eligible for the HRA? YES ☐ NO ☐
Are union employees eligible for participation? _____
Will elections be supplied to AmeriFlex electronically? YES ☐ NO ☐
Employer contribution per participant: Single _____ EE/Spouse _____ EE/Child _____ Family _____
When are funds available? Day one (annual basis at beginning of plan year) ☐ As contributed (pro-rata basis) ☐
NOTE: If the HRA is funding all or a portion of the insurance deductible AND the carrier's deductible year does not match the Plan Year selected, please list the date AmeriFlex should replenish the HRA: _____
If the initial plan year is a short plan year, participants' accounts will: Be pro-rated based on remaining pays ☐ Be credited with the full annual contribution ☐
If a participant enters the plan mid-plan year, they receive: The full annual contribution ☐ A pro-rated contribution ☐
Can participants carry over unused funds? YES ☐ NO ☐ Maximum carryover: % _____ $ _____
Must participants meet a deductible before the HRA becomes active? YES ☐ NO ☐ Is AmeriFlex tracking this deductible? YES ☐ NO ☐
Is an FSA offered? YES ☐ NO ☐ Which pays first? FSA ☐ HRA ☐
If a participant terminates his or her employment for any reason, including but not limited to disability, retirement, layoff, or voluntary resignation, any unused amounts in his or her HRA:
Are forfeited ☐ May be spent down until the account balance is depleted ☐
Is an HDHP in place? YES (integrated HRA with HDHP) ☐ NO (stand-alone HRA) ☐ If YES, does the HRA cover: In-network ☐ Out-of-Network ☐
Will the HRA cover any pharmacy expenses? YES ☐ NO ☐ If YES, does the HRA cover OTC Only, Rx Only, or Both OTC and Rx? _____
If Rx Only, please see below for a description of the IIAS Debit Card limitations at pharmacy locations and choose either: IIAS-HET (Healthcare Eligible Total) or IIAS-Rx Only (Rx Subtotaling)
Beginning 7/1/09, the IRS requires mandatory auto-substantiation of pharmacy purchases using Inventory Information Approval Systems (IIAS). There are two levels of IIAS that a pharmacy can choose to install:

☐ 1) Healthcare Eligible Total (HET): Credit/Debit card terminals at these pharmacies can only separate grocery/non-medical items from all healthcare eligible items (perfect for FSA plans) but cannot further separate healthcare eligible items into OTC and Rx categories.

☐ 2) Prescription Subtotaling (Rx): Credit/Debit card terminals at these pharmacies can separate grocery/non-medical items from all healthcare eligible items AND separate OTC and Rx items for plans that only allow one or the other.

Visit www.sig-is.org to find participating merchants in each category. Rx Only may be preferred for deductible plans to help prevent fraudulent purchases of OTC items.
Excluded items: Vision ☐ Dental ☐ OTC ☐ Rx ☐ Doctor ☐ Hospital ☐ Lab ☐ Chiropractic ☐ Other ☐
Special Processing Notes: _____

C. Commuter Reimbursement Arrangement:

New Plan: Plan year start: _____ Plan year end: _____ Is this a short plan year? YES ☐ NO ☐ If yes, next plan year must be a full 12 month plan.
Next plan year start: _____ End: _____ Original effective date: _____

Annual maximum for Parking (IRS maximum for 2009 is $230/month) : $ _____ Annual maximum for Transit (IRS maximum for 2009 is $230/month): $ _____

D. Health Savings Account:

Please select the HSA enrollment option: Paper Based ☐ Online ☐

E. VEBA

Does Employer have a corporate resolution in place? YES ☐ NO ☐ Name of Trustee Plan (Trust): _____

PLEASE NOTE: Please review the above information carefully before submission. Once the new client application is submitted and plan documents are generated and sent, all changes will require an amendment fee even if the plan year has not started.

IF APPLICABLE, THIS SECTION MUST BE COMPLETED FOR ALL NEW ACCOUNTS.

▶ NEW CLIENT APPLICATION SECTION

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Additional Locations and Affiliated Employer Information:

Location #1

Legal name of employer: _____ Contact Person: _____

Is this an affiliated employer or an additional location? Affiliated Employer ☐ Additional Location ☐

Does this location require separate reporting/funding? YES ☐ NO ☐

Telephone: _____ Fax: _____

Employer mailing address: _____

City: _____ State: _____ Zip: _____

Benefits contact: _____

Number of pays per year: _____ Number of withholdings per year: _____ Dates to skip: _____

Employer president: _____

EIN: _____

Duration of pay period: (from) _____ (to) _____ Day of the week paid: _____

Date of first pre-tax withholding for the Flex Plan: _____

Location #2

Legal name of employer: _____ Contact Person: _____

Is this an affiliated employer or an additional location? Affiliated Employer ☐ Additional Location ☐

Does this location require separate reporting/funding? YES ☐ NO ☐

Telephone: _____ Fax: _____

Employer mailing address: _____

City: _____ State: _____ Zip: _____

Benefits contact: _____

Number of pays per year: _____ Number of withholdings per year: _____ Dates to skip: _____

Employer president: _____

EIN: _____

Duration of pay period: (from) _____ (to) _____ Day of the week paid: _____

Date of first pre-tax withholding for the Flex Plan: _____

Location #3

Legal name of employer: _____ Contact Person: _____

Is this an affiliated employer or an additional location? Affiliated Employer ☐ Additional Location ☐

Does this location require separate reporting/funding? YES ☐ NO ☐

Telephone: _____ Fax: _____

Employer mailing address: _____

City: _____ State: _____ Zip: _____

Benefits contact: _____

Number of pays per year: _____ Number of withholdings per year: _____ Dates to skip: _____

Employer president: _____

EIN: _____

Duration of pay period: (from) _____ (to) _____ Day of the week paid: _____

Date of first pre-tax withholding for the Flex Plan: _____

NEW CLIENT APPLICATION SECTION 4

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There are two funding options available for funding your account(s), Daily ACH or Weekly ACH. Once the plan year begins, AmeriFlex will email a claims notification with the total amount of the previous day's transactions (daily ACH) or with the previous week's transactions (weekly ACH). Within 24 hours of sending the claims notification, AmeriFlex will debit the employer's pre-designated claims account for the required funds. Administrative fees are debited via ACH on a monthly basis.

Weekly ACH/Debit: With discounted pricing and automated, weekly debits, the weekly ACH/Debit funding option offers greater value and convenience to employers. With the weekly ACH/Debit funding option, the employer pre-funds an amount equal to one-twelfth (1/12) of the annual elections to the AmeriFlex Flex Claims Account. Each week, the employer will receive an email from AmeriFlex notifying them that an invoice for the previous week's transactions is available to review online through the AmeriFlex Invoice Manager system. AmeriFlex will debit the employer's pre-designated claims account within 24 hours for the required funds.

Daily ACH/Debit: With the daily ACH/Debit funding option, employers will receive a daily email notifying them that an invoice for the previous day's transactions is available to review online through the AmeriFlex Invoice Manager system. AmeriFlex will debit the employer's pre-designated claims account within 24 hours for the required funds.

Company Name: _____

Please select a Funding Option and complete the Bank Authorization Agreement on the next page:

- ☐ Weekly ACH/Debit
- ☐ Daily ACH/Debit

AUTHORIZATION AGREEMENT FOR DEBITS AND CREDITS

NEW CLIENT APPLICATION SECTION 4

AMERIFLEX® www.flex125.com

We, _____, hereinafter called CLIENT, hereby authorize AmeriFlex, hereinafter called COMPANY, to initiate debits and/or credits to or from our Bank Account indicated at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and or credit the same to such account. We acknowledge that the origination of ACH transactions to or from our account must comply with the provisions of U.S. law.

FUNDING CLAIMS and PREFUND Depository*

Name of the Bank: _____

City: _____ State: _____ Zip: _____

Routing Number: _____ Account Number: _____

Account Type (Select One): Checking Account ☐ Savings Account ☐

*Serves as a liquidity deposit to prevent yOour account from going negative in weeks with high claims activity. Prefund must be replenished as soon as it drops below 1/12 of annual plan elections.

This authorization is to remain in full force and effect until COMPANY has received written notification from CLIENT of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

COBRA Premium Reimbursement Depository*

Name of the Bank: _____

City: _____ State: _____ Zip: _____

Routing Number: _____ Account Number: _____

Account Type (Select One): Checking Account ☐ Savings Account ☐

*Allows AmeriFlex to electronically deposit all collected monthly COBRA premiums directly into your bank account, usually by the 15th of the month following each premium period. You may download a "remittance report" through AmeriFlex's online COBRA portal to see a full accounting and reconciliation of each monthly electronic deposit.

This authorization is to remain in full force and effect until COMPANY has received written notification from CLIENT of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

ADMINISTRATION FEES—Depository (Complete only if different from above)

Name of the Bank: _____

City: _____ State: _____ Zip: _____

Routing Number: _____ Account Number: _____

Account Type (Select One): Checking Account ☐ Savings Account ☐

This authorization is to remain in full force and effect until COMPANY has received written notification from CLIENT of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Authorization (please print): _____

Date: _____ Signature (required): _____

Authorized Individual to sign/act on behalf of CLIENT: _____

Client tax ID#: _____

Please Mail or Fax Original to:

AmeriFlex
Attn: Finance Department
302 Fellowship, Suite 100
Mount Laurel, NJ 08054
Fax: 208.247.5932

Office Use Only

Date received: _____

Date of Instruction: _____

ID Number: _____

CORPORATE

COBRA APPLICANTS MUST COMPLETE THIS SECTION.

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COBRA Administration Information

Please complete the following for each sponsored COBRA/Direct Billing Plan. Make additional copies of this page as needed.

Carrier Name: _____ Insurance Type (Medical, Dental, Vision, EAP, etc.): _____

Plan Name: _____

(HMO, PPO, POS, DMO, etc.) NOTE: Must be unique across all employer sponsored plans and used for all correspondence.

Plan Policy Number: _____ Next Plan Anniversary Date: _____ Fully Insured? YES ☐ NO ☐

Cust. Srv. Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Address: _____

Is this plan available to a specific Division? YES ☐ NO ☐ Division Name:

Coverage Termination: Date of Qualifying Event ☐ End of Month/Extended Employer Notice Rule ☐

Does this Plan offer Conversion? YES ☐ NO ☐

Does this employer charge 50% premium surcharge during disability extensions under COBRA? YES ☐ NO ☐

Plan Rate Type: Composite ☐ Age/Gender based (include copy of rate table) ☐

If plan rates are Age/Gender based, does the carrier adjust the member's premium on their birth date ☐ or plan anniversary ☐

Composite Rate Table

Please provide rates for the current and prior plan years which are needed in the event that there are any active participants prior to the new effective plans and rates.

Coverage Level	Monthly Premium (Prior Year)	Monthly Premium (Current Year)
Employee Only		
Employee + Spouse		
Employee + Child		
Employee + Children		
Employee + Family		
Employee + 1 dependent		
Employee + 2 dependents		
Spouse Only		
Spouse + Child		
Spouse + Children		
Child Only		

Comments/Special Instructions

COBRA APPLICANTS MUST COMPLETE THIS SECTION.

AMERIFLEX® www.flex125.com

COBRA Administration Information

Please complete the following for each sponsored COBRA/Direct Billing Plan. Make additional copies of this page as needed.

Carrier Name: _____ Insurance Type (Medical, Dental, Vision, EAP, etc.): _____

Plan Name: _____

(HMO, PPO, POS, DMO, etc.) NOTE: Must be unique across all employer sponsored plans and used for all correspondence.

Plan Policy Number: _____ Next Plan Anniversary Date: _____ Fully Insured? YES ☐ NO ☐

Cust. Srv. Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Address: _____

Is this plan available to a specific Division? YES ☐ NO ☐ Division Name:

Coverage Termination: Date of Qualifying Event ☐ End of Month/Extended Employer Notice Rule ☐

Does this Plan offer Conversion? YES ☐ NO ☐

Does this employer charge 50% premium surcharge during disability extensions under COBRA? YES ☐ NO ☐

Plan Rate Type: Composite ☐ Age/Gender based (include copy of rate table) ☐

If plan rates are Age/Gender based, does the carrier adjust the member's premium on their birth date ☐ or plan anniversary ☐

Composite Rate Table

Please provide rates for the current and prior plan years which are needed in the event that there are any active participants prior to the new effective plans and rates.

Coverage Level	Monthly Premium (Prior Year)	Monthly Premium (Current Year)
Employee Only		
Employee + Spouse		
Employee + Child		
Employee + Children		
Employee + Family		
Employee + 1 dependent		
Employee + 2 dependents		
Spouse Only		
Spouse + Child		
Spouse + Children		
Child Only		

Comments/Special Instructions

COBRA APPLICANTS MUST COMPLETE THIS SECTION.

AMERIFLEX® www.flex125.com

COBRA Administration Information

Please complete the following for each sponsored COBRA/Direct Billing Plan. Make additional copies of this page as needed.

Carrier Name: _____ Insurance Type (Medical, Dental, Vision, EAP, etc.): _____

Plan Name: _____

(HMO, PPO, POS, DMO, etc.) NOTE: Must be unique across all employer sponsored plans and used for all correspondence.

Plan Policy Number: _____ Next Plan Anniversary Date: _____ Fully Insured? YES ☐ NO ☐

Cust. Srv. Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Address: _____

Is this plan available to a specific Division? YES ☐ NO ☐ Division Name:

Coverage Termination: Date of Qualifying Event ☐ End of Month/Extended Employer Notice Rule ☐

Does this Plan offer Conversion? YES ☐ NO ☐

Does this employer charge 50% premium surcharge during disability extensions under COBRA? YES ☐ NO ☐

Plan Rate Type: Composite ☐ Age/Gender based (include copy of rate table) ☐

If plan rates are Age/Gender based, does the carrier adjust the member's premium on their birth date ☐ or plan anniversary ☐

Composite Rate Table

Please provide rates for the current and prior plan years which are needed in the event that there are any active participants prior to the new effective plans and rates.

Coverage Level	Monthly Premium (Prior Year)	Monthly Premium (Current Year)
Employee Only		
Employee + Spouse		
Employee + Child		
Employee + Children		
Employee + Family		
Employee + 1 dependent		
Employee + 2 dependents		
Spouse Only		
Spouse + Child		
Spouse + Children		
Child Only		

Comments/Special Instructions

COBRA APPLICANTS MUST COMPLETE THIS SECTION.

AMERIFLEX® www.flex125.com

COBRA Administration Information

Please complete the following for each sponsored COBRA/Direct Billing Plan. Make additional copies of this page as needed.

Carrier Name: _____ Insurance Type (Medical, Dental, Vision, EAP, etc.): _____

Plan Name: _____

(HMO, PPO, POS, DMO, etc.) NOTE: Must be unique across all employer sponsored plans and used for all correspondence.

Plan Policy Number: _____ Next Plan Anniversary Date: _____ Fully Insured? YES ☐ NO ☐

Cust. Srv. Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Contact: _____ Phone: _____ Fax*: _____ Email: _____

Enrollment Address: _____

Is this plan available to a specific Division? YES ☐ NO ☐ Division Name:

Coverage Termination: Date of Qualifying Event ☐ End of Month/Extended Employer Notice Rule ☐

Does this Plan offer Conversion? YES ☐ NO ☐

Does this employer charge 50% premium surcharge during disability extensions under COBRA? YES ☐ NO ☐

Plan Rate Type: Composite ☐ Age/Gender based (include copy of rate table) ☐

If plan rates are Age/Gender based, does the carrier adjust the member's premium on their birth date ☐ or plan anniversary ☐

Composite Rate Table

Please provide rates for the current and prior plan years which are needed in the event that there are any active participants prior to the new effective plans and rates.

Coverage Level	Monthly Premium (Prior Year)	Monthly Premium (Current Year)
Employee Only		
Employee + Spouse		
Employee + Child		
Employee + Children		
Employee + Family		
Employee + 1 dependent		
Employee + 2 dependents		
Spouse Only		
Spouse + Child		
Spouse + Children		
Child Only		

Comments/Special Instructions