PAYFLEX®

New Client Checklist

Welcome to PayFlex. The first step in the set up process is completion of the New Client Checklist Form. We use this form to collect critical information about your plan. Please complete all applicable sections on this form and submit it to implementation@payflex.com 60 days prior to your plan start date. Should you require any assistance in completing this form, please contact us at 1-855-462-3056 or send an e-mail to CBClientSupport@payflex.com.

Services Requested

Plan Start Date	Plan End Date

Requested Services

Please complete the required sections below for each service type selected.

Note: The HRA is only available for the small group market segment (2 to 100 employees), unless the HRA is paired with an FSA or HSA.

Note: Any days listed on the New Client Checklist represent calendar days.

- ☐ Health Reimbursement Account (HRA) – complete sections 1, 2, 3, 8, 9, 10, 11
- ☐ Flexible Spending Account (FSA)* - complete sections 1, 2, 4, 8, 9, 10
- ☐ Dependent Care Account (DCFSA) – complete sections 1, 2, 5, 8, 9, 10
- ☐ Limited Purpose Flexible Spending Account (LPFSA)* – complete sections 1, 2, 6, 8, 9, 10
- ☐ Health Savings Account (HSA) – complete sections 1, 2, 7, 8, 9, 10

* IRS rules don't allow a member to contribute to an HSA if they're covered by a general-purpose FSA. By limiting the FSA reimbursement to dental and vision expenses, the member can participate in both a LPFSA and HSA. To pair an HSA plan with LPFSA, complete Section 6.

Section 1 - Customer Information

Employer's Full Legal Name and Address

Federal Tax ID (TIN Number)	Plan Sponsor Number	CSA Number (internal use only)

Corporate Structure

☐ C-Corp ☐ S-Corp* ☐ LLC* ☐ Partnership* ☐ LLP * ☐ Non-Profit ☐ Other _____

*Self-employed individuals (i.e. sole proprietor, partner in a partnership, an outside director, members of an LLC) and a more-than-2% shareholder of an S-Corp cannot participate in an FSA, HRA nor Transportation plan, as the IRS definition of employee doesn't include a self-employed individual.

Broker Contact:	Employer Contact:
Contact Name: _____	Contact Name: _____
Contact/Title: _____	Contact/Title: _____
Address/City/State/ZIP: _____	Address/City/State/ZIP: _____
_____	_____
Phone: _____	Phone: _____
E-mail: _____	E-mail: _____

Form Completed By (Print Name and Title):

This signature certifies that I have carefully reviewed the information contained in this document and have verified the accuracy of each benefit plan as described below.

Employer/Broker Signature (required)	Date

Section 2 – Enrollment

Market Segment *(Based on number of eligible employees.)* ☐ Small Group (2 to 100) ☐ Select (101 to 299)	Estimated Number of Eligible Employees	Estimated Number of Members (*This would include all eligible employees and dependents.)*

Enrollment Source

What method will you use to report the initial open enrollment file? For on-going enrollment changes, you'll need to use the online employer portal.

- ☐ PayFlex Employer Portal
- ☐ Enrollment File (must be in the standard PayFlex file format)
- ☐ Integrated with Medical Enrollment (small groups (2 to 100 employees) only – using the medical eList tool)

Section 3 - Health Reimbursement Account (HRA)

Eligible Expense Types

What eligible expenses will be covered by the HRA plan?

☐ Medical (choose one that applies)

☐ Medical Deductible Only ☐ Medical Deductible, Copay, Coinsurance

☐ Medical Deductible, Copay, Coinsurance, and all 213(d) Eligible Medical Expenses
(this includes all medical/pharmacy covered services and both In- and Out-of-Network providers)

☐ Pharmacy (Pharmacy deductible, copay, and coinsurance will be covered)

Network Services

☐ In- and Out-of-Network Providers ☐ In-Network Providers Only

Employer HRA Funding Amounts

How much will you allocate for each member's HRA? The funding amount will be determined by the member's coverage status (i.e. employee only, family, etc.).

☐ Employee / Family
Employee $_____ Family $_____

☐ 3 Tier
Employee $_____ Employee + 1 $_____ Family $_____

☐ 4 Tier
Employee $_____ Employee + CH $_____ Employee + Spouse $_____ Family $_____

HRA Funding Contribution Schedule

The standard is to fund the HRA in full at the beginning of the plan year; however, your plan can pro-rate funding monthly or quarterly. There's no proration option for new hire or status level changes.

☐ Full funding available at the beginning of the plan year

☐ Monthly The funding is prorated and available at the beginning of each month.
(example: total HRA funding for the plan year is $1,200; the employee will get $100 each month for 12 months)

☐ Quarterly The funding is prorated and available at the beginning of every quarter. (example: total HRA funding for the plan year is $1,200; the employee will get $300 each quarter for 4 quarters)

Employee Upfront Deductible

You may choose to have members pay an upfront deductible amount prior to using the HRA Fund.

☐ No ☐ Yes

Employee Upfront Deductible Amounts

If you answered Yes to the upfront deductible, please indicate the upfront amount.

☐ Employee / Family
Employee $_____ Family $_____

☐ 3 Tier
Employee $_____ Employee + 1 $_____ Family $_____

☐ 4 Tier
Employee $_____ Employee + CH $_____ Employee + Spouse $_____ Family $_____

HRA Rollover

Allow members to rollover remaining HRA dollars at the end of the plan year into the next plan year to be used for expenses incurred in the new plan year.

☐ No ☐ Yes

☐ Rollover full amount with no caps or percentage restrictions

☐ Rollover Percentage of available balance _____%

☐ Cap rollover at a specific dollar amount $_____

Percent Reimbursement

Reimburse a certain percentage of HRA eligible expenses, with the remaining amount to be paid by the member.

☐ 100% ☐ Other: _____% (from 10% – 90%, must be in 10% increments)

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ 30 Days ☐ 60 Days ☐ 90 Days

Section 4 - Flexible Spending Account (FSA)

Debit Card

*The debit card is **not** an option if you offer a stacked HRA/FSA plan design.*

If No is selected for the debit card, the medical claims will automatically cross over from the medical plan and reimburse the member.

☐ No ☐ Yes

Debit Card Copay Matching

This information will be used to substantiate debit card transactions.

☐ No – copayments on the medical plan

☐ Yes – copayments on the medical plan (must provide detailed plan design listing the copay amounts)

Maximum Contribution Amount

The maximum salary contribution amount allowed is limited to the IRS amount. .

$_____

Payroll Contribution Frequency

Health care FSA contributions will automatically post to the member's account based on the payroll frequency and first payroll date.

☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Semi-Monthly - 1st and 15th (24)

☐ Semi-Monthly - 15th and Last Day (24) ☐ Monthly - 1st, 15th or Last Day (12)

First Payroll Contribution Date (*Must be on or after the plan start date.)*

_____/_____/_____

Carryover

Your plan can allow members to carry over up to $500 of unused health care FSA dollars at the end of the plan year.

Note: FSA carryover is not an option if your plan has an FSA grace period.

Note: An FSA balance can carry over to an LPFSA if the member is enrolled in an HSA in the new plan year.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year carryover.

☐ No ☐ Yes

☐ $500

☐ Other: $_____

If Yes, is carryover in place for current plan year? ☐ No ☐ Yes

If Yes, will PayFlex take over current plan year carryover? ☐ No ☐ Yes

Grace Period

An FSA grace period allows members to be reimbursed for eligible medical expenses incurred up to 2 months and 15 days after the plan year ends. If your health care FSA plan has a grace period, the run out period should be no less than 90 days after the end of the plan year.

Note: If your plan has an FSA grace period, you cannot also offer FSA carryover.

Must be in the standard PayFlex file format, if you want PayFlex to take over your current plan year grace period.

☐ No ☐ Yes

If Yes, is grace period in place for current plan year? ☐ No ☐ Yes

If Yes, will PayFlex take over current plan year grace period? ☐ No ☐ Yes

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ 30 Days ☐ 60 Days ☐ 90 Days

Do you offer an HRA plan with the FSA plan?

☐ No – not offering HRA ☐ Yes - FSA pays first ☐ Yes - HRA pays first

Section 5 - Dependent Care Account (DCFSA)

Payroll Contribution Frequency

DCFSA contributions will automatically post to the member's account based on the payroll frequency and first payroll date.

☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Semi-Monthly - 1st and 15th (24)

☐ Semi-Monthly - 15th and Last Day (24) ☐ Monthly - 1st, 15th or Last Day (12)

First Payroll Contribution Date (*Must be on or after the plan start date.)*

_____/_____/_____

Grace Period

An FSA grace period allows members to be reimbursed for eligible dependent care expenses incurred up to 2 months and 15 days after the plan year ends. If your DCFSA plan has a grace period, the run-out period should be no less than 90 days after the end of the plan year.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year grace period.

☐ No ☐ Yes

If Yes, is grace period in place for current plan year? ☐ No ☐ Yes

If Yes, will PayFlex take over current plan year grace period? ☐ No ☐ Yes

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ 30 Days ☐ 60 Days ☐ 90 Days

Section 6 - Limited Purpose Flexible Spending Account (LPFSA)

Debit Card

*The debit card is **not** an option if you offer a stacked HRA/ FSA plan design.*

If No is selected for the debit card, the eligible claims will automatically crossover from the medical plan and reimburse the member.

☐ No ☐ Yes

Debit Card Copay Matching

This information will be used to substantiate debit card transactions.

☐ No – copayments on the medical plan

☐ Yes – copayments on the medical plan (must provide detailed plan design listing the copay amounts)

Eligible Expense Types

Eligible medical expenses covered by the LPFSA plan.

☐ Dental and Vision ☐ Dental Only ☐ Vision Only

Maximum Contribution Amount

The maximum salary contribution amount allowed is limited to the IRS amount.

$_____

Payroll Contribution Frequency

LPFSA contributions will automatically post to the member's account based on the payroll frequency and first payroll date.

☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Semi-Monthly - 1st and 15th (24)

☐ Semi-Monthly - 15th and Last Day (24) ☐ Monthly - 1st, 15th or Last Day (12)

First Payroll Contribution Date (*Must be on or after the plan start date.)*

_____/_____/_____

Carryover

Your plan can allow members to carry over up to $500 of unused health care FSA dollars at the end of the plan year.

Note: FSA carryover is not an option if your plan has an FSA grace period.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year carryover.

☐ No ☐ Yes

☐ $500

☐ Other: $_____

If Yes, is carryover in place for current plan year? ☐ No ☐ Yes

If Yes, will PayFlex take over current plan year carryover? ☐ No ☐ Yes

Grace Period

An FSA grace period allows members to be reimbursed for eligible expenses incurred up to 2 months and 15 days after the plan year ends. If your health care FSA plan has a grace period the run out period should be no less than 90 days after the end of the plan year.

Note: If your plan has an FSA grace period you cannot also offer FSA carryover.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year grace period.

☐ No ☐ Yes

If Yes, is grace period in place for current plan year? ☐ No ☐ Yes

If Yes, will PayFlex take over current plan year grace period? ☐ No ☐ Yes

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ 30 Days ☐ 60 Days ☐ 90 Days

Do you offer a Limited HRA or HSA plan with the LPFSA plan?

☐ No – not offering Limited HRA or HSA ☐ Yes - LPFSA pays first ☐ Yes - HRA pays first

Section 7 - Health Savings Account (HSA)

HSA

Are you offering an HSA for members enrolled in a Qualified High Deductible Health Plan?

☐ No ☐ Yes

Employer Contribution

All HSA contributions that you report will be posted via the employer portal. PayFlex will fund the individual HSAs via ACH withdrawal from your bank account.

☐ No ☐ Yes

Section 8 - Employer Banking Arrangement

This section authorizes PayFlex Systems USA, Inc. ("PayFlex") to initiate debit and credit entries to the bank account you (the "Client") designate below. This authorization is to remain in full effect until written notice of its termination is supplied by you to PayFlex.

- ☐ Complete ALL required banking information (Section 8).
- ☐ Attach a copy of a voided check from the account. If you don't have checks for this account, ask your bank to provide a MICR encoding specification sheet.
- ☐ Complete and sign the Check Image – Signature Request Form (Section 9) and return to PayFlex with the New Client Checklist form.
- ☐ Complete and sign the ACH Authorization Release (Section 10) and return to PayFlex with the New Client Checklist form.
- ☐ Apply the necessary ACH filters required for debit entry with your bank (Section 10).

IMPORTANT:

- PayFlex will be issuing checks for FSA and HRA claims on behalf of Client. Because of this, you must provide a checking account.
- If you're using an existing bank account that is NOT solely used for a PayFlex product, ensure that the starting check number allows enough of a gap in the check number range to avoid producing duplicate checks.
- Any banking changes will require the completion of a new banking form and a voided check/MICR specification sheet. Please allow up to 72 business hours from the date of notification to complete the banking change.
- The bank account will be subject to a $1.00 (Non-Refundable) pre-notification to confirm that the account is valid and live.

Bank/Depository Name and Address

Bank Account Number	Bank Routing Number	Starting Check Number *If starting check number is not provided we'll start with check number 1001*

Authorization to Disburse

Signature of Client's Authorized Representative (required): _____ Date: _____

Printed Name & Title of Authorized Representative: _____

Contact Phone Number: _____

Client hereby authorizes PayFlex Systems USA, Inc. as a limited agent for the purpose of withdrawing funds from the account indicated above at the named financial institution for the payment of claims under a benefit plan established by Client for the benefit of its employees. Client agrees that the account shall be fully funded by Client to assure that all necessary funding, as applicable, is available to pay claims and any applicable fees. Client understands and agrees that PayFlex Systems USA, Inc. shall have no obligations to pay claims Client does not sufficiently fund with the account.

☐ Client hereby authorizes PayFlex Systems USA, Inc. to initiate ACH (automated clearing house) transfer entries for the depository indicated above for claims reimbursement and any applicable fees at the depository named above, hereinafter called Depository. Client acknowledges that the origination of these transactions to/from its account must comply with the provisions of applicable law.

☐ (Applies only if using a debit card) Client hereby authorizes PayFlex Systems USA, Inc. to initiate ACH (automated clearing house) transfer entries for the depository indicated above for daily debit card transactions. Bounced automated withdrawals from Client's account will incur a $100 charge and will require immediate action to prevent cards from being turned off.

Section 9 – Electronic Check Signature

Check Image – Signature Request Form

Please complete the following, so that we have a signature to place on printed checks:

Check Signer – Basic Information

Full Name (Please Print): _____

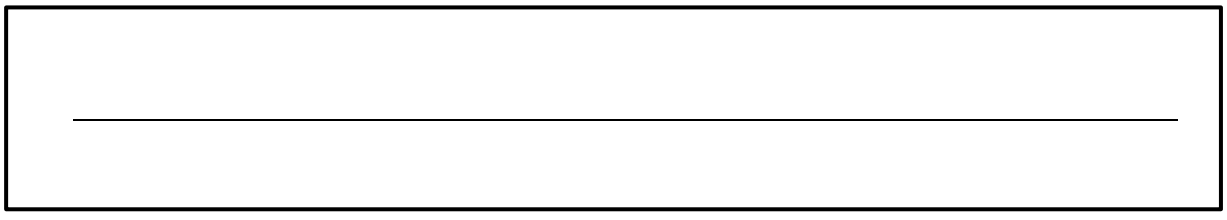
Company: _____

Title: _____

Check Signature

Please provide a signature in the box below. This is the signature that will be placed on checks printed on behalf of your organization. Please keep the signature within the black box below – sign with black ink.

Sign Here:



Section 10 – ACH Authorization Release

ACH Authorization Release	BMO/Harris Bank Filter* Information	
Employers: This form MUST be reproduced and completed on your company's letterhead. A business card of the signatory and a voided check (if checks are drawn from the account) should accompany this form, or the program live date may be delayed. Once completed, please provide to your benefits administrator.	Submitting Bank (ODFI):	Harris Bank F/K/A M&I Bank
	Company Name (Account Name):	Med-I-Bank
	Routing Number: 075000051Origination ID:	07500005
	Company ID (Daily POS Settlement):	1383261866
	Company ID (Resubmits):	W383261866
	Company ID (HSA Items):	9383261866
☐ New Customer ☐ Current Customer – Update Only		

Corporate Employer

_____ HEREBY authorizes Alegeus Technologies LLC to initiate ACH (automated clearing house) transfer entries for the following depository:

Financial Institution Name			
Address			
City		State	ZIP Code
Routing and Transit Number	Bank Account Number	Type of Account *(Please check one)* ☐ Checking Account ☐ Savings Account	
Information Provided by (Please print your name)			
Signature			
Title	Today's Date		

ADMINISTRATION USE ONLY

Verified by Administrator Implementation	Verification Date
Date to Set-Up	Date Settlement Set-Up

Acceptance

I have read the Policy for ACH Failures and have discussed any concerns with my Implementation Manager. I understand the process and will ensure that the process has been adopted by my organization.		
Printed Name	Title	
Signature ✍		Date

Section 11 – Representations required for all Health Reimbursement Accounts (HRA)

This form is a representation from the employer that the HRA PayFlex is administering with plan years beginning on or after January 1, 2014 on behalf of the employer complies with the Affordable Care Act (ACA) prohibition provisions. Administration of the accounts is provided pursuant to the separate services agreement in effect. By signing this form and checking the appropriate box, the employer represents that its HRA is/are:

☐ Integrated HRA ☐ Retiree-only HRA ☐ HIPAA-excepted HRA
☐ Small Benefit HRA

In addition, by signing this form, the employer further represents:

- The employer will promptly notify PayFlex of any changes with respect to the HRA eligibility terms or the employer's group health coverage that impact the above requirements;
- The employer is aware that it may be subject to fees, penalties and other costs if coverage is provided to members under an HRA without satisfying the applicable requirements; and
- The employer is aware that it is the employer's obligation to either satisfy any new requirements regarding the definition of an integrated HRA or to promptly notify PayFlex that such new requirements are not satisfied.
- The employer in consultation with its legal counsel has determined that the HRA design selected above complies with ACA requirements.

The employer acknowledges that PayFlex is relying upon these representations in administering HRAs for employer.

Employer Name	
HRA Plan Name	
Primary Contact Name	
Authorized Plan Sponsor Signature ✍	**Date**