

HEALTH SAVINGS ACCOUNT (HSA) DIRECT PLAN DESIGN GUIDE



Please complete this form and return to Horizon 45 days before your effective date so we can properly administer your plan.

All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Employer's Name _____

Employer's Street Address _____

City _____ State _____ ZIP Code _____

Employer's Tax I.D. Number (required) _____

Type of Corporation S Corporation* C Corporation Partnership* Sole Proprietor*
 Political Subdivision/Church LLC* Non-Profit Other _____

**2% or more shareholders of an S Corporation, along with partners in a partnership, sole proprietors and members of an LLC or PLLP do not have access to an FSA.*

Number of Employees Eligible for Plan: _____

HR Contact:

(Responsible for signing the Plan Design Guide and approving the plan design)

Name _____ Title _____

Phone Number () _____

Email Address _____

Finance Contact:

(Has access to all plan information when calling Horizon and will automatically be granted full access to the Spending Account Employer Portal)

Main Contact Person _____ Title _____

Phone Number () _____

Email Address _____

Additional Contact Person:

(Has access to the plan information indicated below when calling Horizon. Access to the Spending Account Employer Portal may be granted by the Main Contact who will decide what online access is assigned by logging in to the Spending Account Employer Portal)

Additional Contact Person _____ Title _____

Phone Number () _____

Email Address _____

Additional Contact Person has access to when contacting Horizon: All plan information

* Log into the Spending Account Employer Portal to grant access to additional users or to add more contacts.

II. AGENCY/BROKERAGE INFORMATION

Agent/Broker Name (if applicable) _____ Email Address _____

Agent/Broker Code _____ Agent/Broker Phone _____

Agency/Brokerage Name (if applicable) _____ Email Address _____

Agency/Brokerage Code _____ Agency/Brokerage Phone _____

Agency/Brokerage Tax ID _____ - _____ Agency/Brokerage Address _____

III. TRANSFER OF ADMINISTRATION

Is Horizon taking over administrative services from another HSA administrator? Yes No

If yes, participants who wish to transfer dollars are required to complete the Transfer Request Form after the account is established.

IV. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health Plan Group Number _____ Health Plan Account Manager _____ Effective date _____

Group size: (check one)

- SHBP Public
- Small (2-50) Labor
- Mid (51-99) Large / National / Jumbo (100+)

Is your plan fully insured or self insured? Fully insured Self insured

V. ENROLLMENT DATA

Participant eligibility will automatically be set up based on health plan enrollment.

VI. CONTRIBUTION INFORMATION

Select one of the following contribution methods:

1. **Direct Deposit/ACH Push:** An ACH push is a customer or member initiated transaction of an electronic transfer of funds. Horizon will notify you to provide the information needed to set up the Direct Deposit/ ACH Push program.
2. **Spending Account Employer Portal:** If you are using the Horizon Spending Account Employer Portal, there are two ways to make online contributions:
 - a. Schedule an ACH pull and Horizon will initiate an electronic transfer from your company’s bank account to the designated employee’s HSAs. With this method, you use the Spending Account Employer Portal to identify employee accounts and contribution amounts for each pull transaction.
 - b. From the Spending Account Employer Portal, you can create and upload a contribution file directly into our system. This data is then used to generate an ACH pull transaction.
3. **Secure File Transfer with ACH pull:** This option allows a group to create and upload a contribution file to a secure site. An ACH pull will not be initiated unless a contribution file is received. Horizon will notify you to provide the information needed to set up this contribution method.

Account funding must be initiated by you through the standard electronic file format before each ACH transaction can occur. (Required if electronic file is selected)

If you selected option 2 or 3, complete the banking information below:

I hereby authorize Horizon to charge our bank account through Automated Clearinghouse for **HSA contributions**. The following bank account information is provided to Horizon for initiation of this procedure.

Bank Name _____ Type of Account: Checking Savings

Bank ABA Number _____
(The ABA number is the nine-digit number located in the lower left corner of your check.)

Bank Account Number _____

Employer Contributions: Will the employer contribute to the accounts? Yes No

VII. FLEXIBLE SPENDING ACCOUNT INFORMATION

Do you wish to offer a Limited Purpose FSA (LPFSA)?

- Yes - please complete LPFSA Addendum
- No

Eligibility *Required for Plan documents (generally matches that of the health plan.)*

Employees must work at least _____ hours per week to be eligible

Benefits will begin on: (select **only** one):

- First of the month following date of hire
- Date of hire
- First *day* after completion of the waiting period 30 days 60 days 90 days Other _____
- First of the *month* after completion of the waiting period 30 days 60 days 90 days Other _____

VIII. ADMINISTRATIVE TIPS

ONLINE ACCESS: horizonblue.com/employers

With Horizon, your employees have access to a powerful tool for managing their HSA. By registering with horizonblue.com/employers, your employees can:

- Open an HSA
- Make withdrawals form their account
- Enroll in direct deposit
- Make online contributions
- View recent claims or reimbursement requests
- Create and view a customized statement
- Manage their personal profile
- Request a debit card for a dependent(s)

You can also access forms and enrollment materials at **horizonblue.com/employers**.

COORDINATING WITH AN FSA: For participants that have an FSA and an HSA, the FSA provides reimbursement for permitted benefits such as vision and dental care benefits.

PLAN DOCUMENTS: Horizon sends a Summary Plan Description (SPD) only if part of a cafeteria plan. The documents will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.

IX. SIGNATURES

It is agreed that necessary information concerning current and future employees and/or their dependents who participate in this Plan, and employees whose participation is to be changed or discontinued, shall be provided to Horizon on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date _____

Printed Name _____ Title _____