

**BENEFIT STRATEGIES INITIAL CLIENT INFORMATION SHEET**

PLAN SPONSOR (EMPLOYER): \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

TAX ID #: \_\_\_\_\_

# OF BENEFIT ELIGIBLE EE'S? \_\_\_\_\_ TOTAL # OF EMPLOYEES? \_\_\_\_\_ IF CURRENTLY HAVE AN FSA, # OF PARTICIPANTS? \_\_\_\_\_

TYPE OF COMPANY (CIRCLE ONE): C-CORP. S-CORP. PARTNERSHIP SOLE PROP. NON PROFIT OTHER: \_\_\_\_\_ STATE ORGANIZED: \_\_\_\_\_

**BROKER INFORMATION**

AGENCY: \_\_\_\_\_ REPRESENTATIVE: \_\_\_\_\_

CONTACT BROKER FIRST?  YES  NO NOTES FOR CONTACTING CLIENT: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PLAN INFORMATION**

SERVICES OF INTEREST:  Premium Conversion Plan  Parking Account  Tuition Reimbursement  
 Health Care Reimbursement Acct  Mass Transit Account  HIRD Reporting  
 Dependent Care Assistance Acct  Cobra  Massachusetts Health Connector  
 HRA - Health Reimbursement Arrangement

INTENDED BSL EFFECTIVE DATE: \_\_\_\_\_ PLAN YEAR (I.E. JANUARY 1 - DECEMBER 31): \_\_\_\_\_

PRE-TAX PREMIUMS:  MEDICAL  DENTAL  LIFE  STD  LTD  OTHER: \_\_\_\_\_

POP ELECTION IS: (CHECK ONE)  ANNUAL ENROLLMENT  CARRY OVER ENROLLMENT  NEGATIVE ENROLLMENT

HEALTH CARE FSA	MAX. ELECTION:	\$	MIN. ELECTION:	\$	ER CONTRIBUTION:	\$
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DEPENDENT CARE FSA	MAX. ELECTION:	\$	MIN. ELECTION:	\$	ER CONTRIBUTION:	\$
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2½-MONTH GRACE PERIOD?  YES  NO

**MEETINGS**

WILL YOU REQUIRE BSL REPRESENTATION AT ANY ENROLLMENT MEETING(S)?  YES  NO Notes: \_\_\_\_\_

WILL ENROLLMENT KITS BE NEEDED?  Paper Kits(Enter Fee Below)? How Many? \_\_\_\_\_  Emailed PDF Kit? Notes: \_\_\_\_\_

**FEES**

1ST YEAR FEES:	INSTALLATION	\$	FSA ADMIN	\$	/ACCT/MONTH
	WHO PAYS?	<input type="checkbox"/> CLIENT <input type="checkbox"/> BROKER	WHO PAYS?	<input type="checkbox"/> CLIENT <input type="checkbox"/> BROKER	\$75 MIN /MONTH

2ND YEAR FEES	RENEWAL	\$	FSA ADMIN	\$	/ACCT/MONTH
	WHO PAYS?	<input type="checkbox"/> CLIENT <input type="checkbox"/> BROKER	WHO PAYS?	<input type="checkbox"/> CLIENT <input type="checkbox"/> BROKER	\$75 MIN / MONTH

**FLEXEXPRESS® DEBIT CARD FEES:**

EMPLOYEE:	\$	DEPENDENT:	\$
WHO PAYS?	<input type="checkbox"/> CLIENT <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> BROKER	WHO PAYS?	<input type="checkbox"/> CLIENT <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> BROKER

PAPER ENROLLMENT KITS? \$ \_\_\_\_\_ / PER BENEFIT ELIGIBLE EMPLOYEE

NON-DISCRIMINATION TESTING?  YES  NO \$ \_\_\_\_\_ / PER YEAR NOTES: \_\_\_\_\_

OTHER FEES? (IF YES PROVIDE DETAILS IN NOTES) NOTES: \_\_\_\_\_

BSL REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_

If you have any questions in regards to this form please contact our Sales & Marketing Department at (888) 401-FLEX (3539). Please fax all completed forms to (603) 647-4668. We will contact you for further information. Thank you and we look forward to working with you.

AC  OL  N/L  -FL\_\_\_\_\_

