



Initial Client Information

Employer's Legal Name:			
Mailing Address:	City:	State:	Zip:
Street Address:	City:	State:	Zip:
Tax ID:	State Organized:		
Divisions:	Is Separate billing needed for divisions? <input type="checkbox"/> Yes* <input type="checkbox"/> No		
*If Yes - Divisional billing notes:			
Industry: (Ex. Bank or Retail)		EIN Number:	
Type of Company: (Circle One)	C-Corp.	S-Corp.*	Partnership Sole Prop. Non Profit Other:
<small>* A self-employed individual, partner or person who owns more than 2% of the outstanding stock is not eligible to enroll</small>			
Total Number of Employees:		Number of Benefit Eligible Employees:	
Primary Contact			
Primary Contact:		Title:	
E-Mail:	Telephone: ()	Fax: ()	
Broker			
Agency:		Broker:	
Copy Broker on all emails: <input type="checkbox"/> Yes <input type="checkbox"/> No		Notes for Contacting Client:	
E-Mail:	Telephone: ()	Fax: ()	
Address:	City:	State:	Zip:
Plan Information			
<input type="checkbox"/> COBRA <input type="checkbox"/> Commonwealth Health Connector <input type="checkbox"/> Commuter Choice (Parking & Transit) <input type="checkbox"/> Flexible Spending Accounts (FSA)		<input type="checkbox"/> Health Reimbursement Arrangement (HRA) <input type="checkbox"/> HIRD Tracking (Massachusetts Employers Only) <input type="checkbox"/> Premium Conversion Plan (POP) <input type="checkbox"/> Tuition Reimbursement	
Intended BSL Effective Date:		Fiscal Year End Date:	
Plan Year: (Ex. January 1 - December 31)			
<input type="checkbox"/> Short plan year (If short plan is FSA- Proration of Dependent Care election is required, Health Care is recommended)			
Plan Notes:			
<small>(please note here if plan start dates or effective dates are different for multiple plans)</small>			

Section 125 Benefit Plans

Company Name:

Section 125 Contact:

Same as primary contact Access to Benefit Strategies employer portal

Title:

E-Mail:

Telephone: ()

Fax: ()

Will you require representation at enrollment meetings? Yes* No *Date & Time:

Enrollment Materials? Email PDF materials Paper kits* *Paper kits: \$ /kit *Number of kits needed:

Eligibility Requirements

	Hours worked/week (To qualify for benefits)	Waiting Period for New Employees (I.E. 1 st of month following 30 days)
Premium Conversion Plan		
Health Care Reimbursement Account		
Dependent Care Reimbursement Account		
Commonwealth Health Connector		(cannot be longer than 2 months)

Are part time employees excluded from the definition of 'eligible employee' Yes* No

*If Yes, a part time employee is defined as an employee who works less than? Hours per week

Do you want to exclude employees covered under a collective bargaining agreement? Yes No

Plan Type: Single Employer Plan
 Controlled Group (Please complete below)

Participating Employer Name	Federal Tax ID #	City / State / Zip

Premium Conversion Plan (POP)

Pre- Tax Premiums Dental Disability Insurance HSA Life Medical Vision Other:

Pop Election Annual Enrollment Carry Over Enrollment Negative Enrollment

Cash back in lieu of benefits? Yes* No *Please explain:

Effective Date of your First Plan Document: Do you offer an HSA? Yes No HRA? Yes No

Plan Documents

Plan Name:

Plan Number:

Who is responsible for plan documents? Benefit Strategies* Other

*If Benefit Strategies, please indicate: New Plan Restate Existing Plan

Commonwealth Health Connector Insurance (please skip this section if not interested)

One or more of the following classes of employees may be excluded, please check all that apply Don't Exclude Any

Employees under age 18 Temporary Employees Part Time Employees
(average fewer than 64 hours per month)

Wait Staff, Service Employees or Service Bartenders (average less than \$400 in monthly earnings) Students (employed as interns or as cooperative education student workers) Seasonal Employees (Under a U.S. J-1 student visa or a U.S. H2B visa, and who are enrolled in travel insurance)

Employers are not required to pay any portion of the "Commonwealth Health Connector Insurance" premiums. If the Employer would like to contribute to the premium, please list the percentage here (If none list 0%) %

Flexible Spending Account (FSA)

No Yes* (Companies with 20 or more employees are usually subject to COBRA regulations)

Is the Plan Subject to COBRA? *If Yes, is administrative done: In house? Yes No

By Benefit Strategies? Yes No

If administered by another provider please add providers name, phone number and address below:

COBRA Provider's Name:

Telephone: ()

Address:

City:

State:

Zip:

Is your plan subject to FMLA? Yes* No (*In most cases companies with 50 employees or more are subject to FMLA)

Maximum Election

Minimum Election

Employer Contribution

Health Care Reimbursement Account (HCA)

\$

\$

\$

Dependent Care Reimbursement Account (DCA)

\$

\$

\$

2 ½ Month Grace Period: Yes No

Run Out: 90 Days Other:

Will Benefit Strategies be handling the run-out for the previous FSA provider? Yes* No

*If Yes, please provide the pertinent demographic and balance information

HEART Act of 2008

Will you take advantage of the HEART Act of 2008 to permit Qualified Reservist Distributions (QRD)? Yes* No

*If Yes, what is the effective date? / / (Must be after June 18, 2008)

*Please select one of the following to indicate how you would like QRD processed:

- The entire amount elected for the HCA for the plan year minus reimbursements already received
- The amount contributed to the HCA as of QRD date minus any reimbursements already received (This is BSL's default)
- Other, the amount not to exceed the full HCA election minus reimbursements (please list this amount) \$

Dependent Care Spend Down

If an employee terminates participation in the Dependent Care Reimbursement Accounts, can they continue to be reimbursed for Eligible dependent care expenses through the end of the plan year? Yes* No *Benefit Strategies' default

Note: Reimbursement will not exceed amount contributed by employee prior to plan termination

Payroll Frequency

How does your payroll system round elections? Round Up Round Down No Rounding

Payroll Group # or Name:	Weekly	Bi-Weekly	Semi-Monthly	1 st Deduction Date	Number of Payrolls	
				MM/DD/YY	1 st plan year	Subsequent plan year
1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

FSA Fees

	First Year	Renewal
Plan Installation & Renewal Services	\$ Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client	\$ Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client
Monthly Claims Administration Fee	\$ /Acct/Month \$100 Min/Month Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client	\$ /Acct/Month \$100 Min/Month Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client
Non-discrimination Testing <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

FlexExpress © Debit Card Fees

Employee Debit Card \$	Additional Dependent Debit Card \$
Who Pays? <input type="checkbox"/> Client <input type="checkbox"/> Broker <input type="checkbox"/> Employee	Who Pays? <input type="checkbox"/> Client <input type="checkbox"/> Broker <input type="checkbox"/> Employee