



**PURCHASER DETAILS**

**(1) CONTACT INFORMATION**

<b>Contact Name:</b>		<b>Email (required):</b>	
Title:		Telephone:	
<b>Purchaser Name:</b>		Business Federal ID#:	
Physical Address: <i>(no PO Box)</i>		City:	State: Zip:
Mailing Address:		City:	State: Zip:
Billing Contact Name: <i>(if different from primary contact)</i>		Email:	
Billing Mailing Address Name: <i>(if different from primary contact)</i>		City:	State: Zip:
NAICS/SIC Code:		Total # Employees:	
Nature of Business:		Total # Benefit Eligible Employees:	
Tax Filing Status:		<input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Non-Profit <input type="checkbox"/> LLC <input type="checkbox"/> Other:	
Health Insurance Carrier:		Carrier Group ID#:	Renewal Date:
Carrier AM/Rep Name:		AM/Rep Email:	
<b>Are you a current TASC Purchaser?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>If Yes, please provide your 12-Digit TASC ID#:</b>	

**(2) SERVICE OFFERINGS & FEES**

Select TASC Subscription Services, enter the proposed fees, and complete each corresponding section. Set-Up fee payments are due at the time of application submission. **(South Dakota residents add 4.5% sales tax; West Virginia residents add 6.0%.)**

Subscription Services:	One Time Set-Up Fees	Administration Fees	Minimum Admin Fee	Annual Renewal Fees	Additional Services and Fees
<input type="checkbox"/> FlexSystem FSA	\$	\$	\$	\$	\$
<input type="checkbox"/> FlexSystem POP	\$ n/a	\$	\$ n/a	\$ n/a	\$ n/a
<input type="checkbox"/> TASC HSA	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC GiveBack	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC HRA	\$	\$	\$	\$	\$ <input type="checkbox"/> TASC HRA Debit Card
<input type="checkbox"/> TASC INTEGRATED FUNDED HRA	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC RETIREE FUNDED HRA	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC COBRA	\$	\$	\$	\$	\$ <input type="checkbox"/> QB Takeover
<input type="checkbox"/> TASC Retiree Billing	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC FMLA	\$	\$	\$	\$	\$ <input type="checkbox"/> Eligibility Determination
<input type="checkbox"/> TASC ACA Employer Reporting	\$	\$	\$	\$	\$ <input type="checkbox"/> TASC ACA Employer Reporting

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<input type="checkbox"/> TASC ERISA	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC PCORI (with TASC ERISA)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC PCORI (w/out TASC ERISA)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC Form 5500 Preparation	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC Non-Discrimination Testing	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC HIPAA	\$	\$	\$	\$	\$
<b>TASC SUITES (Select one)</b>					
<input type="checkbox"/> Suite 1: ERISA, HIPAA, FMLA	\$	\$	\$	\$	\$
<input type="checkbox"/> Suite 2: ERISA, HIPAA, FSA	\$	\$	\$	\$	\$
<input type="checkbox"/> Suite 3: ERISA, HIPAA, COBRA	\$	\$	\$	\$	\$
<input type="checkbox"/> Suite 4: ERISA, HIPAA, COBRA, FSA	\$	\$	\$	\$	\$
<input type="checkbox"/> Suite 5: ERISA, HIPAA, COBRA, FMLA	\$	\$	\$	\$	\$
<input type="checkbox"/> Suite 6: ERISA, HIPAA, COBRA, FSA, FMLA	\$	\$	\$	\$	\$
<input type="checkbox"/> Suite 7: HIPAA, COBRA, FSA, FMLA	\$	\$	\$	\$	\$
<input type="checkbox"/> Suite 8: HIPAA, COBRA	\$	\$	\$	\$	\$
<b>SUITE Add-On Offerings</b>					
<input type="checkbox"/> TASC ACA Employer Reporting (S)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC Form 5500 Preparation (S)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC Form 990 Preparation (FHRA) (S)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC Summary of Benefits and Coverage Document Preparation (FHRA) (S)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC Non-Discrim Testing (S)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC HSA (S)	\$	\$	\$	\$	\$
<input type="checkbox"/> TASC HRA (S)	\$	\$	\$	\$	\$
<input type="checkbox"/> Account Package	\$	\$	\$	\$	\$
<b>TOTAL ADD-ON OFFERINGS TO BE BILLED</b>					
<b>TOTAL FEES:</b>	\$	\$	\$	\$	\$

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### (3) BILLING INFORMATION

#### Billing Options

- TASC Automatic Check Processing (ACH)<sup>1</sup> – *complete Banking Information below*
  - Pay by Invoice
  - Credit Card – *only available for fees submitted with this Plan Application, not future billing.*
- \*FHRA funding TBD. May be to trustee.*

#### Billing Frequency

- Monthly – *only available with ACH funding (select above)*
- Quarterly
- Annually

#### Banking Information

This information will be used to process payments for services rendered.

Financial Institution Name			
Bank Routing Number		Bank Account Number	

**Account Funding** (TASC will initiate ACH debits from the bank account and financial institution named in the account funding section. Plan funding payments will be electronically deducted from the indicated bank account and automatically submitted on your scheduled payroll contribution dates.)

<input type="checkbox"/> Use same ACH information as banking information		<input type="checkbox"/> Use different ACH information as per below	
Financial Institution Name			
Bank Routing Number		Bank Account Number	

#### Credit Card Information

Credit Card information may **only** be used for Initial Setup Fees.

Name on Card			
Card Type		<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover	
Card Number		Expiration Date	

<sup>1</sup>E-Pay is TASC's standard method for submission of *administration fees*. With E-Pay, TASC conveniently deducts your fees from your checking account. Simply complete the box above, signing where indicated. Please note ACH information for each benefit's plan funding will need separate attention in their respective section of the application. All written debit authorizations must agree that the Payer may revoke the authorization only by first notifying the Originator in the manner specified in the authorization. The language in the authorization represents the disclosure requirement associated with the clarification of OFAC economic sanction policies upon ACH Network Participants.

### (4) AUTHORIZATION

This data and information is being provided to implement the Subscription Services purchased. This data and information is subject to the terms of the TASC USA, including TASC's reliance on its timeliness and accuracy.

☒ **Purchaser Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Title:** \_\_\_\_\_

Distributor/Agent Name:		TASC Provider ID #:		Retail Code:	
Primary Account Rep Name:		Email:			

<b>INTERNAL USE ONLY:</b>	
Assist MyTASC ID:	

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## (5) BENEFIT ACCOUNT MANAGEMENT (BAM) OFFERINGS

### (a) FlexSystem FSA

<b>NEW Plan:</b>	Plan Start Date	____/____/____	Plan End Date	____/____/____
<b>Existing Plan:</b>	Plan Start Date	____/____/____	Plan End Date	____/____/____
<input type="checkbox"/> Mid-Year Plan Takeover		<input type="checkbox"/> POP Plan	<input type="checkbox"/> Limited Purpose FSA (LPFSA)	<input type="checkbox"/> LPFSA Needed? <input type="checkbox"/> Mirror the full FSA?
<b>FlexSystem Benefit Account Offerings (select all that apply)</b>				
<input type="checkbox"/>	Healthcare FSA – Medical Expense Reimbursement Account	Maximum		
<input type="checkbox"/>	Dependent Care FSA Reimbursement Account	Maximum		
<input type="checkbox"/>	Transit Reimbursement Account	Maximum		
<input type="checkbox"/>	Parking Reimbursement Account	Maximum		
<input type="checkbox"/>	Medical or Medical Related Premium			
<input type="checkbox"/>	Non Employer Sponsored Premiums			
<input type="checkbox"/>	Voluntary/Group Term Life Insurance Premium			
<input type="checkbox"/>	Disability Insurance Premium			
<input type="checkbox"/>	Supplemental Insurance			
<b>Plan Details</b>				
<input type="checkbox"/>	Elect a terminal restricted card for your Transit and Parking accounts			
<input type="checkbox"/>	Elect Rollover for Transit and/or Parking accounts	End date (180 default)	____/____/____	
<input type="checkbox"/>	Elect Healthcare FSA Carryover	Amount		
<input type="checkbox"/>	Elect a Grace Period ( <i>not available with Carryover</i> )	End date ( <i>75-day maximum</i> )	____/____/____	
<input type="checkbox"/>	Elect a Runout Period	End date	____/____/____	
<input type="checkbox"/>	Offer Employer Sponsored Group Health Insurance to employees			
<input type="checkbox"/>	Additional Payroll Schedules ( <i>If checked, attach additional payroll schedules.</i> )			
<b>Funding</b>				
Number of Contributions in a 12-month Plan Year				
<b>Payroll/Funding Cycle</b>	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____			
First Contribution Date	____/____/____	Second Contribution Date	____/____/____	
Last Contribution Date	____/____/____			
POC Funding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, an POC Addendum and paperwork is required.</i>		
<b>Participant and Eligibility Requirements</b>				
<b>Entry and Probationary Period:</b> Select the employment requirement below that an eligible employee must meet in order to enroll in the FlexSystem Plan at open enrollment, or at the time of hire.				
<input type="checkbox"/>	On the date of hire	<input type="checkbox"/>	First of the month after date of hire	
<input type="checkbox"/>	30 days after date of hire	<input type="checkbox"/>	First of the month after 30 days of continuous employment	
<input type="checkbox"/>	60 days after date of hire	<input type="checkbox"/>	First of the month after 60 days of continuous employment	
<input type="checkbox"/>	90 days after date of hire	<input type="checkbox"/>	Other: _____	
<b>Additional Requirements (select all that apply)</b>				
Included	Excluded	N/A		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Members of bargaining units	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Part-time employees regularly scheduled to work at least ____ hours per week	

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal employees regularly working at least ____ months within a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employees under ____ years of age

### (b) TASC HSA

Plan Start Date	____/____/____	Plan End Date	____/____/____
<b>HSA Benefit Account Offerings</b>			
<input type="checkbox"/>	TASC HSA		
<input type="checkbox"/>	TASC HSA – LIMITED		
<input type="checkbox"/>	TASC HSA - PLAN ONLY		
<b>Funding</b>			
Payroll/Funding Cycle	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
Participant Contribution Schedule	<i>Dates applied to Participant accounts based on above selected payroll cycle.</i>		
	First Contribution Date	____/____/____	Second Contribution Date
	Last Contribution Date	____/____/____	
Employer Contributions	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, please complete all information below:</b>		
Contribution Amount per Coverage Level	Single: \$		Family: \$
Frequency of Employer Contributions	<input type="checkbox"/> One time	Contribution Date: _____	
	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
Employer Contribution Schedule	First Contribution:	____/____/____	Second Contribution:    ____/____/____
For banking holidays, select one option:	<input type="checkbox"/> Apply contributions <b>next</b> business day		<input type="checkbox"/> Apply contributions <b>prior</b> business day
Pro-Rated for Mid-Year Enrollees	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>If Yes, select a method below:</b>
	<input type="checkbox"/> As of Plan Start Date	<input type="checkbox"/> As of Most Recent Quarter	<input type="checkbox"/> Other: _____

### (c) TASC GIVEBACK

Plan Start Date	____/____/____		
<b>Benefit Account Offerings (select all that apply)</b>			
<input type="checkbox"/>	Company Match →	Employee Match per Employee Per Year	
		Employee Match Per Payroll	
<input type="checkbox"/>	Company Enrollment Bonus →	Bonus Amount	
<input type="checkbox"/>	Hold a Fundraiser		
<b>Funding</b>			
Number of contributions in a 12-month Plan Year			
Payroll/Funding Cycle	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
Employer Contributions	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, please complete all information below:</b>		
First Contribution Date	____/____/____	Second Contribution Date	____/____/____
Last Contribution Date	____/____/____		

### (d) TASC HRA

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Plan Start Date	____/____/____	<input type="checkbox"/> HRA Full Administration	<input type="checkbox"/> HRA Self-Administration
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**Plan Information**

Estimated Number of Participants:		Number of Employees (FT+PT)	
Existing HRA Plan in Place?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, please provide the following information:	
ERISA 3-Digit Plan #:			
# of Current Participants:			
Name of Current Administrator:			
Current Run-Out Period:	_____ Days		
Who will administer <u>current</u> Plan Runout?	<input type="checkbox"/> Prior Administrator	<input type="checkbox"/> TASC	
Roll Over/Carry Over:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, maximum \$ to rollover	
Single:		Family:	
Comments:			

**Plan Start**

Select and complete one of the following two options. Indicate the Plan Year dates and when TASC HRA administration begins. HRA Plan Year should match the medical plan year if applicable.

<input type="checkbox"/> <b>New HRA Plan</b> (no current plan exists)	<b>1<sup>st</sup> Year Administration</b>	<b>2<sup>nd</sup> and Successive Years</b>
Plan Start Date:	First day of: ____/____ (mo/yr)	First day of: ____/____ (mo/yr)
# Consecutive Months Continued:	Twelve (12) month period	
<i>Note: Plans need not run on the calendar year (i.e. January 1 - December 31)</i>		
<input type="checkbox"/> <b>Mid-Year Plan Takeover</b> – select <u>one</u> setup option below (Year-to-Date balances must be submitted with enrollments in order to be entered):		
<input type="checkbox"/> Full Plan Year setup; <u>or</u>	Plan Sponsor must submit an aggregate balance report of participant claims paid year-to-date to adjust the Participant HRA balance	
<input type="checkbox"/> Short Plan Year setup: (less than 12 months)	Plan Sponsor must submit an aggregate deductible credit report of participant claims paid year-to-date to adjust the Participant HRA balance. Allows you to extend a deductible credit to your Participants based on the amount of the health insurance deductible that has been satisfied thus far.	
<b>Enter plan dates based on your selected setup:</b>	<b>Plan Start Date</b>	<b>Plan End Date</b>
Current TPA Plan:	____/____/____ (mo/dd/yr)	____/____/____ (mo/dd/yr)
TASC HRA Plan:	____/____/____ (mo/dd/yr)	N/A

**HRA Benefit Account Offerings**

<input type="checkbox"/> Retiree HRA	
<input type="checkbox"/> QSEHRA	
<input type="checkbox"/> Integrated HRA	
Health insurance carrier name	
Health insurance deductible individual	
Health insurance deductible family	

**Participant and Eligibility Requirements**

Select on eligibility requirement below:

<input type="checkbox"/> Eligibility requirements include participation in the named Health Insurance Plan (N/A for QSEHRA Plans); or
<input type="checkbox"/> Eligibility requirements include (select all that apply below):
<input type="checkbox"/> Part-time employees working at least ____ hours of work per week will be included (maximum 29 hours)
<input type="checkbox"/> Current employees completing ____ months of service with the employer will be included (maximum 90 days)
<input type="checkbox"/> New employees completing ____ months of service with the employer will be included (maximum 90 days)

**Benefit Account Reimbursement Options** (select all that apply)

<input type="checkbox"/> Medical deductible	<input type="checkbox"/> Dental
<input type="checkbox"/> Prescription	<input type="checkbox"/> Vision

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<input type="checkbox"/>	Co-insurance	<input type="checkbox"/>	Ortho	
<input type="checkbox"/>	Uninsured Medical	<input type="checkbox"/>	213(d) - (Premiums not included)	
<input type="checkbox"/>	Co-Pays	<input type="checkbox"/>	Individual Medical Premiums	
<input type="checkbox"/>	Individual Dental Premiums	<input type="checkbox"/>	Individual Vision Premiums	
<b>Plan Type (select only ONE option)</b>				
<input type="checkbox"/>	Family Aggregate: expenses can be shared by family members			
<input type="checkbox"/>	By Member: (Embedded Deductible)			
<b>TASC HRA Plan Participant Responsibility (amount participant is responsible for prior to reimbursements)</b>				
Individual Maximum: \$		Family Maximum: \$		
<b>TASC HRA Employer Reimbursements</b>  Regulatory Limits for QSEHRA: Please consult your sales staff for the yearly regulatory limits for QSEHRA single and family	<b>Percentage</b>		<b>Dollar Amount Range</b>	<b>TASC HRA Employer Reimbursed Amount</b>
		%	\$ - \$	\$
		%	\$ - \$	\$
		%	\$ - \$	\$
		%	\$ - \$	\$
	Minimum reimbursement <b>per individual:</b>			
Maximum reimbursement <b>per family:</b>				\$
To fund your TASC HRA Plan, TASC will initiate ACH debits from the financial institution and bank account named below.				
<b>Funding Options</b>	<input type="checkbox"/> Monthly Budgeted (ACH or Invoice)		<input type="checkbox"/> Point of Claims (ACH Only and Premium Services Bid Request Required)	
<b>Bank Information:</b>	<input type="checkbox"/> Use same ACH info from this Application <input type="checkbox"/> Use different ACH information as per below			
Financial Institution Name:		Branch:		
Bank Routing Number (9 digits):		Checking Account #:		
<b>ADMIN ONLY: TASC HRA - Special Instructions:</b> _____				
<b>Funding:</b> _____ % (Minimum of 25%) _____				

## (6) CONTINUATION OFFERINGS

### (a) TASC COBRA

Plan Start Date	____/____/____	<i>Plan Application must be received by 15th of month prior to this start date. COBRA Addendum is needed if requested plan start date does not meet this requirement.</i>	
Number of Takeover Qualified Beneficiaries (TQBs):		Number of Employees On Health Insurance Plan	
<b>COBRA Benefit Account Offerings (select all that apply)</b>			
<input type="checkbox"/>	Include Takeover Qualified Beneficiaries (TQBs). <b>If selected</b> , please include TQB forms for each beneficiary.		
<input type="checkbox"/>	Include Additional Subsidiaries, Affiliates, or Divisions under TASC COBRA. <b>If selected</b> , complete boxes below:		
<b>Qualifying Events</b>			
When a COBRA Qualifying Event occurs, select when you would like the COBRA period to begin:			
<input type="checkbox"/>	First of the month, following the qualifying event	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Day after the Qualifying Event		
<b>Additional COBRA Services (fees apply)</b>			
<input type="checkbox"/>	Carrier Notifications	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Custom Reporting		

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## (b) TASC RETIREE BILLING

Plan Start Date	____/____/____	Plan Application must be received by 15th of month prior to this start date. COBRA Addendum is needed if requested plan start date does not meet this requirement.	
Number of Participating Retirees			
<b>Retiree Billing Benefit Account Offerings</b> (select all that apply)			
<input type="checkbox"/>	Include Takeover Qualified Beneficiaries (TQBs). <b>If selected</b> , please include TQB forms for each beneficiary.		
<input type="checkbox"/>	Include Additional Subsidiaries, Affiliates, or Divisions under TASC Retiree Billing. <b>If selected</b> , complete boxes below:		
Identify all subsidiaries, affiliates, or divisions to include under TASC Retiree Billing and if they require a separate set-up for service communications:			
<b>NAME</b>	<b>SEPARATE</b>	<b>NAME</b>	<b>SEPARATE</b>
1	<input type="checkbox"/>	3	<input type="checkbox"/>
2	<input type="checkbox"/>	4	<input type="checkbox"/>
<b>Qualifying Events</b>			
When a COBRA Qualifying Event occurs, select when you would like the Retiree Billing period to begin:			
<input type="checkbox"/>	First of the month, following the qualifying event	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Day after the Qualifying Event		
<b>Additional Retiree Billing Services</b> (fees apply)			
<input type="checkbox"/>	Carrier Notifications	<input type="checkbox"/>	Custom Reporting
<input type="checkbox"/>	Other:		

## (c) TASC FMLA

Plan Start Date (Plan must start on the 1st of the month. Application must be received at least 5 business days before the requested start date.)	____/____/____		
Do you have employees currently on FMLA leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, how many employees are currently on FMLA leave?			
Does your company policy run FMLA concurrent with worker's compensation and short-term disability plans?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Which method of reporting do you use for FMLA hours?	<input type="checkbox"/> Manual reporting via online form <input type="checkbox"/> Data feed (via recurring file from your timekeeping system)		
Which 12-month FMLA tracking type does your company policy outline?	<input type="checkbox"/> Rolling Backward <input type="checkbox"/> Rolling Forward <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year with Start Date of: ____/____/____		
In what states do you have locations in?			
Do you have any locations that are not eligible for FMLA?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Additional Services</b> (fees apply)			
<input type="checkbox"/>	Eligibility and entitlement determination (free with TASC Suite)	<input type="checkbox"/>	Other:
Identify all subsidiaries, affiliates, or divisions to include under TASC FMLA and if they require a separate set-up for service communications:			
<b>NAME</b>	<b>SEPARATE</b>	<b>NAME</b>	<b>SEPARATE</b>
1	<input type="checkbox"/>	3	<input type="checkbox"/>
2	<input type="checkbox"/>	4	<input type="checkbox"/>

## (7) COMPLIANCE OFFERINGS

### (a) TASC ACA EMPLOYER REPORTING

Plan Start Date - Must be a calendar year - please indicate the calendar year in which you want reporting to start	____/____/____
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Health Insurance Renewal Date	___/___/___
<b>Employer Type (Select One)</b>	
<input type="checkbox"/>	Single ALE (Applicable Large Employer) (one EIN)
<input type="checkbox"/>	Aggregated ALE (more than one EIN)
<input type="checkbox"/>	Non-ALE (under 50 fulltime employees)
<b>Applicable Large Employer Status (ALE) (Select One)</b>	
<input type="checkbox"/>	ALE with fully insured medical plan
<input type="checkbox"/>	ALE with self-insured medical plan
<input type="checkbox"/>	Non-ALE with self-insured medical plan (1094B and 1095B Filing)
<input type="checkbox"/>	ALE with fully insured and self-funded plans running congruently
<b>Controlled Group</b>	
Please indicate if you are a member of <u>any</u> of the following (required):	
<ul style="list-style-type: none"> <li>a Controlled Group of business entities under IRS Section 414(b) or (c);</li> <li>an affiliated service group under IRS Section 414(m); OR</li> <li>an arrangement described under IRS Section 414(o)</li> </ul>	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No
<b>Government Entity</b>	
Are you a Government Entity that has reportable employees under more than one EIN number?	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No
If you answered YES to either question above, please complete the information in the section below for each member entity within the Aggregated ALE, placing the entity with the most employees on top, descending to the entity with the fewest employees. A plan application must be submitted separately for each entity.	
<b>Entity's Legal Name</b>	<b>Entity's EIN Number</b>
<b>Additional Services (Fees apply)</b>	
<input type="checkbox"/>	Minimum essential coverage offer indicator
<input type="checkbox"/>	Variable hour tracking

<b>(b) TASC ERISA</b>		
Plan Start Date	The ERISA contract will be effective the first of the month in which the application is received.	
<b>Plan Information</b> (select all that apply; if no, leave blank)		
	Yes	No
Is Entity Part of:		
- A controlled Group of Corporations under Code Section 414(b)	<input type="checkbox"/>	<input type="checkbox"/>
- A group of Businesses/Trades under common control under Code Section 414(c); or		
- An Affiliated Services Group under Code Section 414(m)		
Are benefits/premiums paid from a single source? (If No, separate applications are required)	<input type="checkbox"/>	<input type="checkbox"/>
Under PPACA, is your current Group Health Plan considered Grandfathered?	<input type="checkbox"/>	<input type="checkbox"/>
Are you considered an Applicable Large Employer (ALE) under the Employer Shared Responsibility Provision of the Affordable Care Act (ACA)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently track employee hours to determine if any variable hour, part-time, or seasonal employees are fulltime employees for purposes of health plan eligibility?	<input type="checkbox"/>	<input type="checkbox"/>

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Do you offer Medicare Part D coverage? <b>If Yes</b> , please select one of the following: <input type="checkbox"/> Creditable <input type="checkbox"/> Non-Creditable <input type="checkbox"/> Both	<input type="checkbox"/>	<input type="checkbox"/>
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Please complete the following information.

A	B Contract Year (mo/dd/yr)	C Benefit Contract Written to Group (G) or Individuals (I)	D Pre-tax Benefit (Y/N)	E Insurance Carrier or Service Provider name	F Is Benefit Self-Insured (SI) or Fully-Insured (FI)	G Total Number of Covered participants (not including Dependents)
Health						
Dental						
Vision						
Life						
AD&D						
STD						
LTD						
Voluntary/Supplemental Life or AD&D						
Wellness						
Employee Assistance Program						
Stop Loss Insurance						
Voluntary Products						
Other ERISA Plans						

**Additional Services** (additional fees may apply)

<input type="checkbox"/>	Medicare Part D Notice	<input type="checkbox"/>	Professional Services (billed hourly)
<input type="checkbox"/>	Additional Benefit Plans (9+)	<input type="checkbox"/>	Form 5500 Late Filing
<input type="checkbox"/>	Carrier Certificates of Coverage attached to Plan Document	<input type="checkbox"/>	PPACA Notices
<input type="checkbox"/>	Wrap Document – Individual/Separate Affiliated Employer		

**(c) TASC PCORI**

Plan Start Date - Stand Alone PCORI will start 07/01, please indicate the year in which you would like reporting to start.

\_\_\_/\_\_\_/\_\_\_

**Current Benefits Status** (select all that apply)

<input type="checkbox"/>	A - Health Reimbursement Arrangement (HRA)
<input type="checkbox"/>	B - TASC HRA Purchaser
<input type="checkbox"/>	C - TASC Non-Excepted Health Flexible Spending Account (NEFSA) Purchaser
<input type="checkbox"/>	D - Self-Insured Health Plan
<input type="checkbox"/>	E - TASC Self-Administered HRA or NEFSA Purchaser

**Participant Counts**

As of the first day of the <b>FIRST</b> month of the plan year:	
As of the first day of the <b>FOURTH</b> month of the plan year:	
As of the first day of the <b>SEVENTH</b> month of the plan year:	
As of the first day of the <b>TENTH</b> month of the plan year:	

INSTRUCTIONS FOR PARTICIPANT COUNT

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**If you selected A only, A and E, or C and E:** Participant counts should equal the number of HRA or NEFSA plan participants on the first day of each quarter of the plan year.

**If you selected A and D or C and D:** Participant counts should equal the total number of self-insured health plan participants on the first day of each quarter during the plan year. Count each health plan participant with self-only coverage and then add to that the number of participants with other than self-only coverage multiplied by 2.35.

**If you selected D only:** Participant counts should equal the total number of self-insured health plan participants on the first day of quarter of the plan year. Count each health plan participant with self-only coverage and then add to that the number of participants with other than self-only coverage multiplied by 2.35.

**If you selected A&B only** and TASC administered your HRA in the previous year, TASC has the necessary counts. If TASC did not have administer your HRA in the previous year, please provide the appropriate counts.

### (d) TASC FORM 5500 PREPARATION

Plan Start Date	____/____/____		
Do you have Late Filings for Form 5500?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If Yes</i> , enter the number of late filings: _____
<b>NOTE:</b> This service offering is for ongoing 5500 plans only, not for customers who are getting 5500 preparation with another offering. If you need a late filing only, please select under TASC ERISA service offering.			
Is Entity Part of:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<ul style="list-style-type: none"> <li>- A controlled Group of Corporations under Code Section 414(b)</li> <li>- A group of Businesses/Trades under common control under Code Section 414(c); or</li> <li>- An Affiliated Services Group under Code Section 414(m)</li> </ul>			
If Benefits/Premiums are NOT paid from a single source, separate applications are required.			

### (e) TASC NON-DISCRIMINATION TESTING

Plan Start Date - Please indicate the plan year to start testing	____/____/____		
Controlled Group: Please indicate if you are a member of any of the following: (required)	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, see below*		
<ul style="list-style-type: none"> <li>- A controlled Group of business entities under IRS Section 414(b) or (c);</li> <li>- An affiliated service group under IRS Section 414(m); or</li> <li>- An arrangement described under IRS Section 414(o).</li> </ul>			
<ul style="list-style-type: none"> <li>• If you selected "Yes" in the above question, please provide a list of all other companies and incorporated business entities.</li> <li>• Indicate on this list which entity or entities' employees participate in the cafeteria plan and indicate the type of corporation for each entity (i.e., C-Corp, Subchapter S Corp, Partnership, etc.).</li> <li>• Note: In general, all employees under a controlled group of employers are considered when performing Plan Non-Discrimination Testing.</li> </ul>			
<b>Testing Options</b> (select all that apply; fill in dates if applicable)			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you need testing for a Premium Only Plan – Section 125 (POP)?</b>	
		Plan Start Date	Plan End Date
		____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you need testing for a Healthcare Flexible Spending Account (FSA)?</b>	
		Plan Start Date	Plan End Date
		____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you need testing for a Dependent Care Flexible Spending Account (FSA)?</b>	
		Plan Start Date	Plan End Date
		____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you need testing for a Health Reimbursement Arrangement (HRA)?</b>	
		Plan Start Date	Plan End Date
		____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you need testing for Self-Insured Medical Plans?</b>	
		Plan Start Date	Plan End Date
		____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you need testing for Group Life Insurance?</b>	

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	Plan Start Date	___/___/___	Plan End Date	___/___/___
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Note: Group employees of all entities must be tested if entity is a member of a controlled group of corporations, trades, or businesses under common control or an affiliated service.

**SPECIAL INSTRUCTIONS**

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