# Universal Subscription Agreement (USA)
# PURCHASER DETAILS

| Submit this completed form with total fees due (on page 4) to TASC via one of the following methods: | Email | Fax | Mail |
|---|---|---|---|
| | newbusiness@tasconline.com | (608) 661-9638 | TASC, c/o New Business Department<br>2302 International Lane, P.O. Box 14140<br>Madison, Wisconsin 53704-3140 |

## GENERAL BUSINESS INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Company Name: | | | | EIN #: | |
| Federal Filing Status: | ☐ C-Corp ☐ S-Corp ☐ Partnership ☐ Sole Proprietor ☐ Non-Profit ☐ LLC ☐ Other | | | | |
| Multi-Employer Group *(check all that apply)* | ☐ PEO ☐ ASO ☐ MEWA ☐ Joint Employer ☐ Integrated Employer<br>☐ Controlled Group ☐ Governmental Entity ☐ Municipality | | | | |
| Total # of Employees: | | Total # of Benefit Eligible Employees: | | Total # of Employees Participating in Group Health Plan Benefits: | |
| Nature of Business: | | | NAICS Code: | | |
| Are you a current TASC Client? | ☐ Yes ☐ No | | If yes, please provide your 12-digit TASC ID: | | |

| | |
|---|---|
| Class and/or Division Setup Required? | ☐ Yes ☐ No<br>**If *Yes*, complete and attach *Class & Division Designation Form (TC-6180)*** |
| >> If Division setup is required, will funding from different bank accounts be required? | ☐ Yes ☐ No<br>**If *Yes*, complete and attach *Bank Account Authorization & Designation Form (TC-6181)*** |
| If multiple accounts, indicate order for payment of requests: | ☐ HRA 1st, FSA 2nd ☐ FSA 1st, HRA 2nd |
| EDI File: | ☐ Yes ☐ No **If *Yes*, complete and attach EDI Application** |

## CLIENT CONTACT INFORMATION

| Client Addresses | Street | City | State | Zip |
|---|---|---|---|---|
| Primary/Physical Address **(no P.O. Box)** | | | | |
| Billing Address ***(if different than Primary Address)*** | | | | |
| Mailing/Shipping Address ***(if different than Primary Address)*** | | | | |

| Authorized Contacts | | | | |
|---|---|---|---|---|
| **Contact Type** | **Contact Name** | **Email *(Required for Online Access)*** | **Phone** | **Primary or Secondary** |
| **Client Primary Company Contact** | | | | ☐ Primary ☐ Secondary |
| Client Billing Contact | | | | ☐ Primary ☐ Secondary |
| Distributor/ Broker | | | | Secondary |
| **List Additional Contacts and associate with Benefit(s) *(if applicable)*** | | | | |
| | | | | Secondary |
| | | | | Secondary |
| | | | | Secondary |

## GENERAL INFORMATION - UNIVERSAL BENEFIT ACCOUNT

| **CONTRIBUTIONS** | |
|---|---|
| If payroll lands on banking holidays, select one option: | ☐ Apply contributions next business day<br>☐ Apply contributions prior business day |
| **Section 125 Plan Document Premium Benefits** | |
| **Do you have an existing Section 125 Plan?** ☐ Yes ☐ No **If Yes, Enter the Plan Original Effective Date:** _____ | |
| ☐ Medical or Medical Related Premium (Group Sponsored):<br>☐ Group Medical Insurance Premium ☐ Dental Premium ☐ Vision Premium<br>☐ Supplemental Insurance (Voluntary Indemnity Plans) – includes cancer, hospital confinement, intensive care, AD&D<br>☐ Disability Insurance Premium (Employee Only)<br>☐ Voluntary/Group Term Life Insurance (Employee Only to $50,000 in death benefits) | |
| **Participant and Eligibility Requirements:** (eligibility for all accounts, except HRAs, will be set as designated here, unless Class and/or Division setup requirement is indicated below). | |
| Waiting period and effective date together **must not exceed 90 days**. Select the employment requirement below that an eligible employee must meet at open enrollment, or at the time of hire. **If eligibility is required by class, complete *Class and Division Designation Form (TC-6180)*.** | |
| ☐ **Waiting Period (enter # of Days):** | |
| **Effective Date:** | ☐ First of the month after waiting period ends<br>☐ First day after waiting period ends ☐ Same day when waiting period ends |

| **Additional Eligibility Requirements** *(select all that apply)* | | | |
|---|---|---|---|
| Included | Excluded | N/A | |
| ☐ | ☐ | ☐ | Members of bargaining units |
| ☐ | ☐ | ☐ | Full or part-time employees regularly scheduled to work at least _____ hours per week |
| ☐ | ☐ | ☐ | Seasonal employees regularly working at least _____ months within a year *(6 mo max)* |
| ☐ | ☐ | ☐ | Employees under _____ years of age |
| **Estimated Total # of TASC Participants:** | | | |

## UNIVERSAL BENEFIT ACCOUNT OFFERING SELECTIONS & FEES

**Check all that apply:**

| | | | |
|---|---|---|---|
| **HEALTHCARE** | **Flexible Spending Accounts** (IRC §125[1]) | ☐ | Healthcare FSA |
| | | ☐ | Limited Purpose Healthcare FSA (LPFSA) |
| | **Health Savings Accounts** | ☐ | Health Savings Account (HSA) |
| | | ☐ | Client-Directed HSA |
| | **Health Reimbursement Accounts** | ☐ | Health Reimbursement Arrangement (HRA) |
| | | ☐ | Integrated Funded HRA (Integrated FHRA) |
| | | ☐ | Retiree Funded HRA (Retiree FHRA) |
| | | ☐ | Dental HRA |
| | | ☐ | Ortho HRA |
| | | ☐ | Vision HRA |
| | | ☐ | Healthcare Premium Reimbursement Arrangement *(Employer-Only Funded)* |
| | | ☐ | Individual Coverage HRA (ICHRA) |
| | | ☐ | Excepted Benefit HRA (EBHRA) |
| | | ☐ | Wellness Reimbursement Arrangement |
| **FRINGE** | **Dependent Care Account** (IRC §125[1]) | ☐ | Dependent Care FSA |
| | **Premium Reimbursement** (IRC §125[1]) | ☐ | Healthcare Premium (NESP) Reimbursement Account |
| | **Commuter** | ☐ | Parking Account |
| | | ☐ | Transit Account |
| | **Awards/Rewards** | ☐ | Wellness Rewards Account |
| | | ☐ | Wellness Reimbursement Account (Non-Tax Advantaged) |
| | | ☐ | Back-up Care Reimbursement Account |
| | | ☐ | Bike Account |

| | | | |
|---|---|---|---|
| | **Accountable Plans** | ☐ | Professional Business Expense Account |
| | | ☐ | Home Office Account |
| | | ☐ | Travel and Business Meals Account |
| | | ☐ | Work Clothes Account |
| | | ☐ | Workplace Tools Account |
| **ED** | **Education Accounts** | ☐ | Tuition Reimbursement Account |
| | | ☐ | Student Loan Reimbursement Account |

[1]***IRC §125:*** *All benefits under a single IRC §125 plan must have the same eligibility and runout rules.*

## UNIVERSAL BENEFIT ACCOUNT: ADD-ON PACKAGES

| | |
|---|---|
| ☐ Integration Package | ☐ Priority Service Package |
| ☐ Co-Branding Package | ☐ Account Compliance Package *(complete next section)* |
| ☐ Plan Optimization Package | ☐ Other: _____ |

**Select ALL Account(s) for *Account Compliance Add-On Package* (separate fees apply for each account selected):**

| | | | |
|---|---|---|---|
| ☐ | Healthcare FSA | ☐ | Dental HRA |
| ☐ | Limited Purpose Healthcare FSA | ☐ | Ortho HRA |
| ☐ | Dependent Care FSA | ☐ | Vision HRA |
| ☐ | Parking Account | ☐ | Individual Coverage HRA (ICHRA) |
| ☐ | Transit Account | ☐ | Excepted Benefit HRA (EBHRA) |
| ☐ | Health Savings Account (HSA) | ☐ | Wellness Reimbursement Arrangement |
| ☐ | Client-Directed HSA | ☐ | Healthcare Premium (NESP) Reimbursement Account |
| ☐ | Health Reimbursement Arrangement (HRA) | ☐ | Tuition Reimbursement Account |

## FEE SUMMARY: UNIVERSAL BENEFIT ACCOUNT

| Level | Tier | PPPM Fee | PEPM Fee* | Monthly Minimum Fee** | Annual Membership Fee *(will be invoiced)* | Fees for Add-On Packages |
|---|---|---|---|---|---|---|
| | | *Enter only one* | | | | |
| | | | | | | |

**If selected, Employee Census must be provided up front – and updated quarterly*
***Only applies with PPPM pricing*

## OTHER OFFERINGS & FEES

| Selected Offerings | One Time Set-Up Fee *(due with Purchaser Details submittal)* | Admin Fee | Minimum Admin Fee | Annual Renewal Fee | Additional Services and Fees |
|---|---|---|---|---|---|
| **Continuation Offerings** | | | | | |
| ☐ COBRA | | | | | ☐ QB Takeover Fee $_____ |
| ☐ Retiree Billing | | | | | |
| ☐ FMLA | | | | | ☐ Eligibility Determination $_____ |
| **Compliance Offerings** | | | | | |
| ☐ ERISA (Full Administration) | | | | | ☐ Late 5500 Filing: $_____ |
| ☐ ERISA Docs Only (100+; no 5500) | | | | | |
| ☐ Medicare Part D Notice | | | | | |
| ☐ PPACA & ERISA Notices | | | | | |
| ☐ PCORI (without ERISA) | | | | | |
| ☐ Form 5500 Preparation ***(see p.21)*** | N/A | | | | ☐ Ongoing ☐ One-Time<br>☐ Late 5500 Filing: $_____ |
| ☐ Non-Discrimination Testing | | | | | |
| ☐ HIPAA Compliance | | | | | |
| ☐ ACA Employer Reporting | | | | | |
| **Documents Only** | | | | | |
| ☐ Premium Only Plan (POP) | N/A | | N/A | N/A | |
| ☐ Plan Only HSA | | | | | |
| ☐ Self-Administration FSA | | | | | |
| ☐ Self-Administration HRA | | | | | |

| **TASC Suites** | | | | | |
|---|---|---|---|---|---|
| ☐ #1: ERISA, HIPAA, FMLA | | | | | |
| ☐ #2: ERISA, HIPAA, COBRA | | | | | |
| ☐ #3: ERISA, HIPAA, COBRA, FMLA | | | | | |
| ☐ #4: HIPAA, COBRA | | | | | |
| **TOTAL FEES (other offerings):** | | | | | |

| **TOTAL FEES DUE WITH APPLICATION:** | |
|---|---|

## BILLING INFORMATION

**Select a payment method for your fees and complete the following information for the selected payment method:**

| **Payment Method:** | ACH (E-Pay)[2] | Credit Card | Invoice | |
|---|---|---|---|---|
| Fees Required w/Purchaser Details submittal[1] | ☐ | ☐ | N/A | ***For Universal Benefit Account sales,*** *Membership Fee, Admin Fee and Add-On Packages for Universal Benefit Account will be invoiced no later than 60 days after setup.* |
| Administration, Membership, Renewal, and Package Fees | ☐ | N/A | ☐ | |
| **Billing Frequency:** | ☐ Annually ☐ Quarterly ☐ Monthly | | | |
| *NOTE: Small groups with 1-15 employees are annual payment only.* | | | | |

| **Banking Information:** | **This information will be used to process payments for services rendered** | | |
|---|---|---|---|
| Bank Name: | | Bank Account Name: | |
| Bank Routing Number: | | Account Number: | |
| Account Type: | ☐ Business Checking ☐ Business Savings<br>☐ Personal Checking ☐ Personal Savings | | |

**Account Funding:**

**If different bank accounts are required by benefit offering or by division, complete and attach *Bank Authorization & Designation Form (TC-6181)***

| | | |
|---|---|---|
| ☐ Use same ACH information as banking information above ⇧ | | **TASC will initiate ACH debits from the bank account and financial institution named in the amount funding section**. Plan funding payments will be electronically deducted from the indicated bank account and automatically submitted on your scheduled payroll contribution dates. |
| ☐ Use different ACH information as per below ⇩ | | |
| Bank Name: | | |
| Bank Account Name: | | |
| Bank Routing Number: | | |
| Account Number: | | |
| Account Type: | ☐ Business Checking ☐ Business Savings<br>☐ Personal Checking ☐ Personal Savings | |

**Credit Card Information:**

**Credit Card information may only be used for initial set-up fees for Offerings indicated as "Other" above.**

| | | | |
|---|---|---|---|
| Name on Card: | | | |
| Card Type: | ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover | | |
| Card Number: | | Expiration Date: | |

[1]Includes, but not limited to; Set-Up Fees for Other Accounts Admin Fees for stand-alone HIPAA, ACA, POP, Self-Admin HRA, Self-Admin FSA, 5500s.

[2]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. 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.

## AUTHORIZATION

The data and information are being provided to implement the services purchased. This data and information are subject to the terms of the TASC Universal Subscription Agreement (USA), including TASC's reliance on its timeliness and accuracy.

**Purchaser Signature:** _____ **Date:** _____

Title: _____

| | | | |
|---|---|---|---|
| Distributor/Agent Name: | | TASC Provider ID #: | |
| List Bill # (if applicable): | | Retail Code (If applicable): | |

| **INTERNAL USE ONLY:** | |
|---|---|
| Assist MyTASC ID: | |

***Complete the applicable sections below based on benefit selections made above.***

## FLEXIBLE SPENDING ACCOUNTS *(check all that apply)*

☐ **Healthcare FSA** ☐ **Limited Purpose Healthcare FSA (LPFSA)**

| | | | | | |
|---|---|---|---|---|---|
| **NEW Plan:** | **Plan Start Date:** | ____/____/_____ | | **Plan End Date:** | ____/____/_____ |
| **EXISTING Plan:** | Plan Start Date: | ____/____/_____ | | Plan End Date: | ____/____/_____ |
| | Current Participant Count: | | ERISA Plan #: | | ☐ Mid-Year Plan Takeover |
| **Name of Administrator:** | | | | | |
| If you have a current FSA, indicate who will administer the plan's Grace and Runout period(s): | ☐ Prior Administrator ☐ TASC | | | | |

### Plan Contributions

| | | | | |
|---|---|---|---|---|
| Healthcare FSA | Minimum (if applicable): | | Maximum Contribution: | |
| Limited Purpose Healthcare FSA | Minimum (if applicable): | | Maximum Contribution: | |

### Plan Details

| | **Healthcare FSA** | | **Limited Purpose Healthcare FSA** | |
|---|---|---|---|---|
| **Carryover** ($500 max) | ☐ Yes | Amount: $_____ | ☐ Yes | Amount: $_____ |
| **Grace Period** (75-day max) *(not available for plans with Carryover)* | ☐ Yes | # of Days: _____<br>End Date: ___/___/___ | ☐ Yes | # of Days: _____<br>End Date: ___/___/___ |
| **Runout Period** *(default 90 days after Plan End Date)*[1] | ☐ Yes | # of Days from Plan Year End: _____<br>Runout End Date: ___/___/___ | ☐ Yes | # of Days from Plan Year End: _____<br>Runout End Date: ___/___/___ |
| **Employer Contributions** | ☐ Yes ☐ No | | ☐ Yes ☐ No | |
| ***If yes***, enter $ amount | $ _____ | | $ _____ | |
| ***If yes***, frequency of Employer Funding will be: | ☐ Same as Employee Deduction Schedule<br>☐ Other (List): _____ | | ☐ Same as Employee Deduction Schedule<br>☐ Other (List): _____ | |
| **Allow Online Enrollment** | ☐ No ☐ Yes >> Open Enrollment Dates: ___/___/____ to ___/___/____ | | ☐ No ☐ Yes >> Open Enrollment Dates: ___/___/____ to ___/___/____ | |

### Termination

**Terminated Participant Coverage:** Select the plan coverage option below for terminated participants

| | |
|---|---|
| ☐ **Full Coverage** after termination<br>☐ **Limited Coverage** after a terminated participant's paid coverage period ends (coverage paid through date) >> | If ***Limited Coverage***, select the plan coverage paid through date:<br>☐ Termination Date ☐ End of the Month of Termination<br>☐ Last Payroll Date |
| **Eligibility End Date:**<br>Select the plan eligibility end date for the last day a terminated participant may incur expenses. | ☐ Termination Date<br>☐ End of the Month of Termination<br>☐ Last Payroll Date *(available for Full Coverage only)*<br>☐ End of the Month of Paid Coverage End Date *(available for Limited Coverage only)* |

| | | |
|---|---|---|
| **Runout Period for Terminated Participants[1]** | ☐ End of Plan Runout<br>☐ _____ Days after Eligibility End Date | ☐ End of Plan Runout<br>☐ _____ Days after Eligibility End Date |
| **Offer Employer-Sponsored Group Health Insurance to Employees?** | | ☐ Yes ☐ No |

| **FSA Benefit Plan Co-pays** | | |
|---|---|---|
| ☐ Office Visits | List: | |
| ☐ Prescriptions | List: | |

**Funding** (funding method will default to automatic ACH Debit on each payroll deduction date unless indicated otherwise)

| | | | |
|---|---|---|---|
| **Number of payroll deductions in 12-mo plan year:** | | | |
| **Employee Deduction Schedule:** | ☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Other (**Enter all Payroll Dates in Special Instructions**): _____ | | |
| **Deduction Dates:** | **First Deduction Date** | **Second Deduction Date** | **Last Deduction Date** |
| | ____/____/____ | ____/____/____ | ____/____/____ |
| **Point of Disbursement Funding[2]** | ☐ Yes ☐ No | | |

[1] ***IRC §125:*** *All benefits under a single IRC §125 plan must have the same eligibility and runout rules.*

[2] *If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## HEALTH SAVINGS ACCOUNTS *(check all that apply)*

☐ **Health Savings Account (HSA)** ☐ **Client Directed HSA**

| | | | |
|---|---|---|---|
| **Plan Start Date:** | ____/____/_____ | **Plan End Date:** | ____/____/_____ |

**Funding** (funding method will default to automatic ACH Debit on each payroll deduction date unless indicated otherwise)

| | | | |
|---|---|---|---|
| **Number of payroll deductions in 12-mo plan year:** | | | |
| **Employee Deduction Schedule:** | ☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Other (**Enter all Payroll Dates in Special Instructions**): _____ | | |
| **Deduction Dates:** | **First Deduction Date** | **Second Deduction Date** | **Last Deduction Date** |
| | ____/____/____ | ____/____/____ | ____/____/____ |
| **Employer Contributions:** | ☐ Yes ☐ No **>> If *Yes*, enter $ amount:** | | |
| ***If yes***, frequency of Employer Funding will be: | ☐ Same as Employee Deduction Schedule<br>☐ Other (List): _____ | | |
| Contribution Amount per Coverage Level: | **Single: $** | | |
| | **Family: $** | | |
| Pro-rated for Mid-Year Enrollees: | ☐ As of Plan Start ☐ As of Most Recent Quarter ☐ Other: _____ | | |
| **Contributions are:** | ☐ **Pretax under a Cafeteria Plan** *(if checked, compl*ete "Premium Benefits Provided Under the Section 125 Plan Document" in the General Business Information section on page one)<br>☐ **Post-Tax** | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | |

## HEALTH REIMBURSEMENT ARRANGEMENTS *(check all that apply)*

- ☐ **Health Reimbursement Arrangement (HRA)**
- ☐ **Vision HRA**
- ☐ **Dental HRA** ☐ **Ortho HRA**
- ☐ **Healthcare Premium Reimbursement Arrangement**
- ☐ **Wellness Reimbursement Arrangement**
- ☐ **Individual Coverage HRA *(complete section B - ICHRA)***
- ☐ **Excepted Benefit HRA *(complete section C - EBHRA)***

| | | | |
|---|---|---|---|
| **Effective Date:** | _____/_____/_____ | | |
| **Plan Information** | | | |
| **Estimated # of New Plan Participants:** | | **# of Employees (FT+PT):** | |
| **Existing HRA Plan in Place?** | ☐ Yes ☐ No If *Yes*, please provide the following information: | | |
| ERISA 3-Digit Plan #: | | **# Current Participants:** | |
| Name of Current Administrator: | | | |
| **Runout for Terminated Participants:** | ☐ End of Benefit Plan Runout ☐ _____Days after Eligibility End Date | | |
| **Allow Rollover:** | ☐ Yes >> If elected, select one timing: | ☐ After Runout End<br>☐ Day 1 of New Plan Year | |
| | ☐ Available Balance (no Maximum) | | |
| | ☐ Maximum Rollover (List): | | |
| | ☐ % of Available Balance (List): | | |

### 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.

| ☐ **New HRA Plan Year** | **Plan Start Date** | **Plan End Date** | **Runout** (Max 365 days) |
|---|---|---|---|
| Plan Year: | _____/_____/_____ | _____/_____/_____ | _____ Days |
| | *Note: Plans need not run on the calendar year (i.e., January 1 – December 31)* | | End Date ___/___/___ |
| ☐ **Mid-Plan Year Takeover** | **Plan Start Date** | **Plan End Date** | **Runout** (Max 365 days) |
| Plan Year: | _____/_____/_____ | _____/_____/_____ | _____ Days |
| Service Start Date: | _____/_____/_____ | | End Date ___/___/___ |

*Plan Sponsor must submit an aggregate balance report of participant claims paid year-to-date to adjust the participant HRA balance.*

### HRA Benefit Account Offerings

| | |
|---|---|
| Health Insurance Carrier Name: | |
| Health Insurance Deductible Individual: | |
| Health Insurance Deductible Family: | |

### HRA Benefit Plan(s) Co-pays

| | | |
|---|---|---|
| ☐ Office Visits | List: | |
| ☐ Prescriptions | List: | |

### Participant and Eligibility Requirements

Select an Eligibility requirement below. If eligibility is required by class, complete Class and Division Designation Form.

☐ Eligibility requirements include participation in the named Health Insurance Plan; - OR –

☐ Eligibility requirements include (select all that apply below):

- ☐ Part-time employees working at least _____ hours of work per week will be included (maximum 29 hours)
- ☐ Current employees completing _____ months of service with the employer will be included (maximum 90 days)
- ☐ New employees completing _____ months of service with the employer will be included (maximum 90 days)

### Benefit Account Reimbursement Options for Standard HRA's (Group sponsored health insurance required)

To ensure accuracy of reimbursement request processing for deductible, co-pay and/or coinsurance HRA Plan Designs, it is required the employee attach a copy of the Carrier's Explanation of Benefits (EOB). If the carrier does not provide an EOB, participants will be required to submit a copy of an online summary/statement in place of the EOB. ***Select all that apply:***

| | |
|---|---|
| ☐ Medical deductible | ☐ Co-insurance |
| ☐ Prescription | ☐ Co-Pays |

☐ 213(d) (all qualified uninsured medical expenses – premiums excluded)

## Plan Type *(select only ONE option)*

☐ Family Aggregate: Expenses can be shared by family members ☐ By Member: Embedded Deductible

## TASC HRA Plan Participant and Employer Responsibility

☐ Employee Pays First (no card option)

| **Individual HRA Deductible $** | | **Family HRA Deductible $** | |
|---|---|---|---|

| **HRA Reimbursement Schedule** | **Percentage** | **Dollar Amount Range** | **HRA Employer Reimbursed Amount** |
|---|---|---|---|
| | % | $ ____ - $ ____ | $ ____ |
| | % | $ ____ - $ ____ | $ ____ |
| | % | $ ____ - $ ____ | $ ____ |
| | % | $ ____ - $ ____ | $ ____ |
| | Maximum Reimbursement **per individual**: | | $ ____ |
| | Maximum Reimbursement **per family:** | | $ ____ |

## Funding (funding **method** will default to **automatic** ACH Debit unless indicated otherwise)

| | |
|---|---|
| **Funding Schedule:** | ☐ Monthly ☐ Custom Schedule (List): _____ |
| **Funding Options:** | ☐ Monthly Budgeted<br>☐ Point of Disbursement[1] (ACH Only) |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## SECTION B - Individual Coverage HRA (ICHRA)

**Effective Date:** _____/_____/_____

## Plan Information

| | | | |
|---|---|---|---|
| **Estimated # of New Plan Participants:** | | **# of Employees (FT+PT):** | |
| **Existing HRA Plan in Place?** | ☐ Yes ☐ No If *Yes*, please provide the following information: | | |
| ERISA 3-Digit Plan #: | | **# Current Participants:** | |
| Name of Current Administrator: | | | |
| **Runout for Terminated Participants:** | ☐ End of Benefit Plan Runout ☐ _____Days after Eligibility End Date | | |
| **Allow Rollover:** | ☐ Yes >> If elected, select one timing: | ☐ After Runout End<br>☐ Day 1 of New Plan Year | |
| | ☐ Available Balance (no Maximum) | | |
| | ☐ Maximum Rollover (List): | | |
| | ☐ % of Available Balance (List): | | |

## 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.

| ☐ **New HRA Plan Year** | **Plan Start Date** | **Plan End Date** | **Runout** (Max 365 days) |
|---|---|---|---|
| Plan Year: | _____/_____/_____ | _____/_____/_____ | _____ Days<br>End Date ___/___/___ |
| | *Note: Plans need not run on the calendar year (i.e., January 1 – December 31)* | | |

| ☐ **Mid-Plan Year Takeover** | **Plan Start Date** | **Plan End Date** | **Runout** (Max 365 days) |
|---|---|---|---|
| Plan Year: | _____/_____/_____ | _____/_____/_____ | _____ Days |
| Service Start Date: | _____/_____/_____ | | End Date ___/___/___ |

*Plan Sponsor must submit an aggregate balance report of participant claims paid year-to-date to adjust the participant HRA balance.*

## Participant and Eligibility Requirements:

**Complete separate *Individual Coverage HRA Class Designation Form (DP-6379)***

## Benefit Account Reimbursement Options for ICHRA *(select all that apply)*

☐ Individual Health Insurance Premiums ☐ 213(d) (all qualified uninsured medical expenses)

## Benefit Accounts Offered with Individual Coverage HRA

(If offering either of the below Benefit Accounts, please select box and complete the appropriate section on this Purchaser Details form)

☐ Healthcare Premium (NESP) Reimbursement Account *(allow employees to pretax premium portion not reimbursed by the employer; cannot be used for Exchange coverage)*

☐ Healthcare FSA

| **TASC HRA Plan Participant & Employer Responsibility:** | **Specify on *ICHRA Class Designation Form (DP-6379)*** |
|---|---|
| **Funding** (funding **method** will default to **automatic** ACH Debit unless indicated otherwise) | |
| **Funding Schedule:** | ☐ Monthly ☐ Custom Schedule (List): _____ |
| **Funding Options:** | ☐ Monthly Budgeted<br>☐ Point of Disbursement[1] (ACH Only) |

*[1]If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## SECTION C – Excepted Benefit HRA (EBHRA)

| **Effective Date:** | _____/_____/_____ |
|---|---|

### Plan Information

| | | | |
|---|---|---|---|
| **Estimated # of New Plan Participants:** | | **# of Employees (FT+PT):** | |
| **Existing HRA Plan in Place?** | ☐ Yes ☐ No | If *Yes*, please provide the following information: | |
| ERISA 3-Digit Plan #: | | **# Current Participants:** | |
| Name of Current Administrator: | | | |
| **Employer Contribution Amount:** | $_____ (subject to IRS annual maximum; indexed in subsequent year) | | |
| **Runout for Terminated Participants:** | ☐ End of Benefit Plan Runout ☐ _____Days after Eligibility End Date | | |
| **Allow Rollover:** | ☐ Yes >> If elected, select one timing: | ☐ After Runout End<br>☐ Day 1 of New Plan Year | |
| | ☐ Available Balance (no Maximum) | | |
| | ☐ Maximum Rollover (List): | | |
| | ☐ % of Available Balance (List): | | |

### 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.

| ☐ **New HRA Plan Year** | **Plan Start Date** | **Plan End Date** | **Runout** (Max 365 days) |
|---|---|---|---|
| Plan Year: | _____/_____/_____<br>*Note: Plans need not run on the calendar year (i.e., January 1 – December 31)* | _____/_____/_____ | _____ Days<br>End Date ___/___/___ |

| ☐ **Mid-Plan Year Takeover** | **Plan Start Date** | **Plan End Date** | **Runout** (Max 365 days) |
|---|---|---|---|
| Plan Year: | _____/_____/_____ | _____/_____/_____ | _____ Days<br>End Date ___/___/___ |
| Service Start Date: | _____/_____/_____ | | |

*Plan Sponsor must submit an aggregate balance report of participant claims paid year-to-date to adjust the participant HRA balance.*

### Participant and Eligibility Requirements

Select an Eligibility requirement below. If eligibility is required by class, complete the *Class and Division Designation Form (TC-6180)*.

☐ Eligibility requirements include (select all that apply below):

- ☐ Current employees completing _____ months of service with the employer will be included (maximum 90 days)
- ☐ New employees completing _____ months of service with the employer will be included (maximum 90 days)

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

☐ Premiums for excepted benefits: ❑ dental ❑ vision ❑ other:_____
☐ 213(d) (all qualified uninsured medical expenses)
☐ COBRA Premiums
☐ Short-Term Limited Duration Insurance (STLDI) premiums

### Funding (funding method will default to automatic ACH Debit unless indicated otherwise)

| **Funding Schedule:** | ☐ Monthly ☐ Custom Schedule (List): _____ |
|---|---|
| **Funding Options:** | ☐ Monthly Budgeted (ACH or invoice)<br>☐ Point of Disbursement[1] |

*[1]If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

**ADMIN ONLY: TASC HRA - Special Instructions:**_____
**Funding: _____ % (Minimum of 25%)**_____

## DEPENDENT CARE FSA

| | | | | | |
|---|---|---|---|---|---|
| **NEW Plan:** | **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | _____/_____/_____ | |
| **EXISTING Plan:** | Plan Start Date: | _____/_____/_____ | Plan End Date: | _____/_____/_____ | |
| | Current Participant Count: | | ERISA Plan #: | | ☐ Mid-Year Plan Takeover |
| **Name of Administrator:** | | | | | |
| If you have a current Dependent Care Account, indicate who will administer the plan's Grace and Runout period(s): | ☐ Prior Administrator ☐ TASC | | | | |
| **Plan Contributions** | | | | | |
| Annual Election: | Minimum (if applicable): | | Maximum Contribution: | | |
| **Plan Details** | | | | | |
| **Grace Period** *(75-day max)* | ☐ Yes | # of Days: _____ End Date: _____/_____/_____ | | | |
| **Runout Period**[1] *(default 90 days after Plan End Date)* | ☐ Yes | # of Days from Plan Year End: _____ Runout End Date: _____/_____/_____ | | | |
| **Employer Contributions** | ☐ Yes ☐ No **>> *If yes***, enter $ amount: _____ | | | | |
| ***If yes***, frequency of Employer Funding will be: | ☐ Same as Employee Deduction Schedule<br>☐ Other (List): _____ | | | | |
| **Termination** | | | | | |
| **Eligibility End Date:** Select the plan eligibility end date for the last day a terminated participant may incur expenses. | ☐ Termination Date<br>☐ End of the Month of Termination<br>☐ Last Payroll Date<br>☐ End of Plan Year *(requires DCAP spend down amendment/plan option)* | | | | |
| **Runout Period for Terminated Participants**[1] | ☐ End of Plan Runout<br>☐ _____ Days after Eligibility End Date | | | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | | | |
| **Offer Employer-Sponsored Group Health Insurance to Employees:** | ☐ Yes ☐ No | | | | |
| **Funding** (funding method will default to automatic ACH Debit on each payroll deduction date unless indicated otherwise) | | | | | |
| **Number of payroll deductions in 12-mo plan year:** | | | | | |
| **Employee Deduction Schedule:** | ☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Other (**Enter all Payroll Dates in Special Instructions**): _____ | | | | |
| **Deduction Dates:** | **First Deduction Date** | **Second Deduction Date** | **Last Deduction Date** | | |
| | _____/_____/_____ | _____/_____/_____ | _____/_____/_____ | | |
| **Point of Disbursement Funding**[2] | ☐ Yes ☐ No | | | | |

[1] ***IRC §125:*** *All benefits under a single IRC §125 plan must have the same eligibility and runout rules.*

[2] *If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## PREMIUM REIMBURSEMENT ACCOUNT

☐ **Healthcare Premium (NESP) Reimbursement Account**

| | | | | | |
|---|---|---|---|---|---|
| **NEW Plan:** | **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | _____/_____/_____ | |
| **EXISTING Plan:** | Plan Start Date: | _____/_____/_____ | Plan End Date: | _____/_____/_____ | |
| | Current Participant Count: | | ERISA Plan #: | | ☐ Mid-Year Plan Takeover |
| **Name of Administrator:** | | | | | |
| If you have a current plan, indicate who will administer the plan's Grace and Runout period(s): | ☐ Prior Administrator ☐ TASC | | | | |
| **Plan Contributions** | | | | | |
| Annual Election | Minimum (if applicable): | | Maximum Contribution: | | |
| **Plan Details** | | | | | |
| **Grace Period** *(75-day max)* | ☐ Yes | # of Days: _____ End Date: _____/_____/_____ | | | |
| **Runout Period**[1] *(default 90 days after Plan End Date)* | ☐ Yes | # of Days from Plan Year End: _____ Runout End Date: _____/_____/_____ | | | |
| **Employer Contributions** *(Note; Not applicable if this account is paired with ICHRA)* | ☐ Yes ☐ No ***>> If yes***, Enter $ _____ ***>> If yes***, frequency of Employer Funding will be (below): ☐ Same as Employee Deduction Schedule ☐ Other (List): _____ | | | | |
| **Termination** | | | | | |
| **Eligibility End Date:** Select the plan eligibility end date for the last day a terminated participant may incur expenses. | ☐ Termination Date ☐ End of the Month of Termination ☐ Last Payroll Date | | | | |
| **Runout Period for Terminated Participants**[1] | ☐ End of Plan Runout ☐ _____ Days after Eligibility End Date | | | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | | | |
| **Offer Employer-Sponsored Group Health Insurance to Employees?** | ☐ Yes ☐ No | | | | |
| **Funding** (funding method will default to automatic ACH Debit on each payroll deduction date unless indicated otherwise) | | | | | |
| **Number of payroll deductions in 12-mo plan year:** | | | | | |
| **Employee Deduction Schedule:** | ☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly ☐ Other (**Enter all Payroll Dates in Special Instructions**): _____ | | | | |
| **Deduction Dates:** | **First Deduction Date** | **Second Deduction Date** | **Last Deduction Date** | | |
| | _____/_____/_____ | _____/_____/_____ | _____/_____/_____ | | |
| **Point of Disbursement Funding**[2] | ☐ Yes ☐ No | | | | |

[1] ***IRC §125:*** *All benefits under a single IRC §125 plan must have the same eligibility and runout rules.*

[2] *If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## COMMUTER ACCOUNTS *(check all that apply)*

☐ **Parking Account** ☐ **Transit Account** *(terminal restricted card required)*

| **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | _____/_____/_____ |
|---|---|---|---|

| | **Parking Account** | **Transit Account** |
|---|---|---|
| **Maximum Employee Contribution:** | | |
| **Elect a terminal restricted card** | ☐ Yes ☐ No | ☐ Yes – **card is required** |
| **Allow Rollover** of full available balance | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Runout Period** (Max 180 days, *default 90 days after Plan End Date*)<br>***Select one per Account:*** | # of days from Date of Service: _____<br>**OR**<br># of days from Plan Year End: _____<br>Runout End Date: ___/___/___ | # of days from Date of Service: _____<br>**OR**<br># of days from Plan Year End: _____<br>Runout End Date: ___/___/___ |
| **Runout Period for Terminated Participants** | ☐ End of Plan Runout<br>☐ _____ Days after Eligibility End Date | ☐ End of Plan Runout<br>☐ _____ Days after Eligibility End Date |
| **Employer Contributions:** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ***If yes***, Enter $ Amount: | | |
| ***If yes***, frequency of Employer Funding will be: | ☐ Same as Employee Deduction Schedule<br>☐ Other Schedule (list below): | ☐ Same as Employee Deduction Schedule<br>☐ Other Schedule (list below): |
| | | |
| **Allow Online Enrollment** | ☐ No<br>☐ Yes >> Open Enrollment Dates: ___/___/___ to ___/___/___ | ☐ No<br>☐ Yes >> Open Enrollment Dates: ___/___/___ to ___/___/___ |

**Funding** (funding method will default to automatic ACH Debit on each payroll deduction date unless indicated otherwise)

| **Number of payroll deductions in 12-mo plan year:** | | | |
|---|---|---|---|
| **Employee Deduction Schedule:** | ☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Other (**Enter all Payroll Dates in Special Instructions**): _____ | | |
| **Deduction Dates:** | **First Deduction Date** | **Second Deduction Date** | **Last Deduction Date** |
| | _____/_____/_____ | _____/_____/_____ | _____/_____/_____ |
| **Point of Disbursement Funding[1]** | ☐ Yes ☐ No | | |

[1] *If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## AWARD/REWARD ACCOUNTS *(check all that apply)*

☐ **Back-up Care Reimbursement Account** ☐ **Bike Account**

☐ **Wellness Reward Account** ☐ **Wellness Reimbursement Account (Non-Tax Advantaged)**

### Back-up Care Reimbursement Account – Plan Details

| | | | |
|---|---|---|---|
| **Plan Start Date:** | **_____/_____/_____** | **Plan End Date:** | **12/31/_____** |
| **Maximum Annual Coverage Amount per Employee:** | | Amount: $ _____ | |
| **Runout Period** (Max 60 Days) | ☐ No<br>☐ Yes >> # of Days: _____ End Date: **_____/_____/_____** | | |
| **Number of contributions in 12-mo plan year:** | | | |
| **Frequency of Employer Contributions:** (When $ are made available to Employees) | ☐ One Time with Contribution Date of: **_____/_____/_____**<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | |
| **Employer Contribution Dates** | **First Contribution Date**<br>**_____/_____/_____** | **Second Contribution Date**<br>**_____/_____/_____** | **Last Contribution Date**<br>**_____/_____/_____** |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout Period for Terminated Participants** | ☐ End of Benefit Plan Runout<br>☐ Days after Eligibility End Date (Enter # of Days: _____) | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

### Bike Account – Plan Details

| | | | |
|---|---|---|---|
| **Plan Start Date:** | **_____/_____/_____** | **Plan End Date:** | **12/31/_____** |
| **Maximum Annual Coverage Amount per Employee:** | | Amount: $ _____ | |
| **Runout Period (Max 60 Days)** | ☐ No<br>☐ Yes >> # of Days: _____ End Date: **_____/_____/_____** | | |
| **Number of contributions in 12-mo plan year:** | | | |
| **Frequency of Employer Contributions:** (When $ are made available to Employees) | ☐ One Time with Contribution Date of: **_____/_____/_____**<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | |
| **Employer Contribution Dates** | **First Contribution Date**<br>**_____/_____/_____** | **Second Contribution Date**<br>**_____/_____/_____** | **Last Contribution Date**<br>**_____/_____/_____** |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout Period for Terminated Participants** | ☐ End of Benefit Plan Runout<br>☐ Days after Eligibility End Date (Enter # of Days: _____) | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## Wellness Reward Account – Plan Details

| | | | |
|---|---|---|---|
| **Describe your Wellness Plan:** ***(be specific)*** | | | |
| **Maximum Annual Reward Amount per Employee:** | $ _____ | | |
| **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | **12/31/_____** |
| **Runout Period** (Max 60 days): | ☐ No<br>☐ Yes **>>** # of Days: _____ End Date: **_____/_____/_____** | | |
| **Number of Contributions in 12-mo plan year:** | | | |
| **Frequency of Employer Contributions** (When $ are made available to Employees) | ☐ One Time with Contribution Date of: **_____/_____/_____**<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | |
| **Employer Contribution Dates:** | **First Contribution Date** | **Second Contribution Date** | **Last Contribution Date** |
| | **_____/_____/_____** | **_____/_____/_____** | **_____/_____/_____** |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout for Terminated Participants:** | ☐ End of Benefit Plan Runout<br>☐ Days after Eligibility End Date (Enter # of Days: _____) | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## Wellness Reimbursement Account (Non-Tax Advantaged) – Plan Details

| | | | |
|---|---|---|---|
| **List Wellness Items to be Reimbursed** ***(be specific)*** | | | |
| **Maximum Annual Reward Amount per Employee:** | $ _____ | | |
| **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | **12/31/_____** |
| **Runout Period** (Max 60 days): | ☐ No<br>☐ Yes **>>** # of Days: _____ End Date: **_____/_____/_____** | | |
| **Number of Contributions in 12-mo plan year:** | | | |
| **Frequency of Employer Contributions: (***When $ are made available to Employees)* | ☐ One Time with Contribution Date of: **_____/_____/_____**<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | |
| **Employer Contribution Dates:** | **First Contribution Date** | **Second Contribution Date** | **Last Contribution Date** |
| | **_____/_____/_____** | **_____/_____/_____** | **_____/_____/_____** |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout for Terminated Participants:** | ☐ End of Benefit Plan Runout<br>☐ Days after Eligibility End Date (Enter # of Days: _____) | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## ACCOUNTABLE PLANS *(check all that apply)*

☐ **Professional Business Expense Account** ☐ **Work Clothes Account** ☐ **Workplace Tool Account**

☐ **Home Office Account** ☐ **Travel and Business Meals Account**

### Professional Business Expense Account – Plan Details

| | | | | |
|---|---|---|---|---|
| **Expenses to be Reimbursed** (list): | | | | |
| **Plan Start Date:** | ____/____/____ | **Plan End Date:** | **12/31/____** | *(plan year runs on a calendar year)* |
| **Maximum Annual Coverage Amount per Employee:** | Amount: $ _____ | | | |
| **Runout Period** (Max 60 Days) | ☐ No ☐ Yes >> # of Days: _____ End Date: ____/____/____ | | | |
| **Number of contributions in 12-mo plan year:** | | | | |
| **Frequency of Employer Contributions:** (When $ are made available to Employees - if annually is selected, required first day of plan year) | ☐ One Time with Contribution Date of: ____/____/____<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | | |
| **Employer Contribution Dates** | **First Contribution Date** | **Second Contribution Date** | **Last Contribution Date** | |
| | ____/____/____ | ____/____/____ | ____/____/____ | |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ No ☐ Yes **If Yes >>** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout Period for Terminated Participants** (Max 60 days): | _____ Days after Eligibility End Date (enter # of days) | | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: ____/____/____ to ____/____/____ | | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

### Home Office Account – Plan Details: The Home Office Account is set up for reimbursement and tracking of common home offices expense. For reimbursement related to rent, utilities, taxes and the like, please consult with your tax professional.

| | | | | |
|---|---|---|---|---|
| **Expenses to be Reimbursed** *(check all that apply):* | ☐ Internet ☐ Phone ☐ Personal Computer<br>☐ Office Supplies ☐ Printer & Printer Supplies | | | |
| **Plan Start Date:** | ____/____/____ | **Plan End Date:** | **12/31/____** | *(plan year runs on a calendar year)* |
| **Maximum Annual Coverage Amount per Employee:** | Amount: $ _____ | | | |
| **Runout Period** (Max 60 Days) | ☐ No ☐ Yes >> # of Days: _____ End Date: ____/____/____ | | | |
| **Number of contributions in 12-mo plan year:** | | | | |
| **Frequency of Employer Contributions:** (When $ are made available to Employees - if annually is selected, required first day of plan year) | ☐ One Time with Contribution Date of: ____/____/____<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | | |
| **Employer Contribution Dates** | **First Contribution Date** | **Second Contribution Date** | **Last Contribution Date** | |
| | ____/____/____ | ____/____/____ | ____/____/____ | |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ No ☐ Yes **If Yes >>** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout Period for Terminated Participants** (Max 60 days): | _____ Days after Eligibility End Date (enter # of days) | | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: ____/____/____ to ____/____/____ | | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## Travel & Business Meals Account – Plan Details

| | | | | |
|---|---|---|---|---|
| **Expenses to be Reimbursed** (list): | | | | |
| **Plan Start Date:** | **____/____/_____** | **Plan End Date:** | **12/31/____** | *(plan year runs on a calendar year)* |
| **Maximum Annual Coverage Amount per Employee:** | Amount: $ _____ | | | |
| **If Per Diem Plan, Select One:** | ☐ Meals & Incidental Expenses<br>☐ Lodging | | | |
| **Runout Period** (Max 60 Days) | ☐ No ☐ Yes >> # of Days: _____ End Date: **____/____/____** | | | |
| **Number of contributions in 12-mo plan year:** | | | | |
| **Frequency of Employer Contributions:** (When $ are made available to Employees - if annually is selected, required first day of plan year) | ☐ One Time with Contribution Date of: **____/____/____**<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | | |
| **Employer Contribution Dates** | **First Contribution Date** | **Second Contribution Date** | **Last Contribution Date** | |
| | **____/____/____** | **____/____/____** | **____/____/____** | |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ No ☐ Yes **If Yes >>** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout Period for Terminated Participants** (Max 60 days): | _____ Days after Eligibility End Date (enter # of days) | | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## Work Clothes Account – Plan Details

| | | | | |
|---|---|---|---|---|
| **Expenses to be Reimbursed** (list): | | | | |
| **Plan Start Date:** | **____/____/_____** | **Plan End Date:** | **12/31/____** | *(plan year runs on a calendar year)* |
| **Maximum Annual Coverage Amount per Employee:** | Amount: $ _____ | | | |
| **Runout Period** (Max 60 Days) | ☐ No ☐ Yes >> # of Days: _____ End Date: **____/____/____** | | | |
| **Number of contributions in 12-mo plan year:** | | | | |
| **Frequency of Employer Contributions:** (When $ are made available to Employees - if annually is selected, required first day of plan year) | ☐ One Time with Contribution Date of: **____/____/____**<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | | |
| **Employer Contribution Dates** | **First Contribution Date** | **Second Contribution Date** | **Last Contribution Date** | |
| | **____/____/____** | **____/____/____** | **____/____/____** | |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ No ☐ Yes **If Yes >>** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout Period for Terminated Participants** (Max 60 days): | _____ Days after Eligibility End Date (enter # of days) | | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

| **Workplace Tool Account – Plan Details** | | | | |
|---|---|---|---|---|
| **Expenses to be Reimbursed** (list): | | | | |
| **Plan Start Date:** | **_____/_____/_____** | **Plan End Date:** | **12/31/_____** | *(plan year runs on a calendar year)* |
| **Maximum Annual Coverage Amount per Employee:** | Amount: $ _____ | | | |
| **Runout Period** (Max 60 Days) | ☐ No ☐ Yes >> # of Days: _____ End Date: **_____/_____/_____** | | | |
| **Number of contributions in 12-mo plan year:** | | | | |
| **Frequency of Employer Contributions:** (When $ are made available to Employees - if annually is selected, required first day of plan year) | ☐ One Time with Contribution Date of: **_____/_____/_____**<br>☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly<br>☐ Quarterly ☐ Annually ☐ Other (explain): _____ | | | |
| **Employer Contribution Dates** | **First Contribution Date** | **Second Contribution Date** | **Last Contribution Date** | |
| | **_____/_____/_____** | **_____/_____/_____** | **_____/_____/_____** | |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ No ☐ Yes **If Yes >>** | ☐ As of Plan Start<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | | |
| **Runout Period for Terminated Participants** (Max 60 days): | _____ Days after Eligibility End Date (enter # of days) | | | |
| **Allow Online Enrollment?** | ☐ No ☐ Yes **>>** Open Enrollment Dates: _____/_____/_____ to _____/_____/_____ | | | |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | | | |
| **Funding Type** *(select one)*: When you are providing funding to TASC | ☐ Contribution Schedule (must match frequency selected for employer contribution dates)<br>☐ Point of Disbursement[1]<br>☐ Custom/Other (Indicate in special instructions) | | | |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## EDUCATION ACCOUNTS *(check all that apply)*

☐ **Tuition Reimbursement Account** ☐ **Student Loan Reimbursement Account**

*Tax reporting required if reimbursement exceeds $5,250/year*

| PLAN DETAILS | Tuition Reimbursement Account | Student Loan Reimbursement Account |
|---|---|---|
| **Plan Start Date:** | _____/_____/_____ | _____/_____/_____ |
| **Plan End Date:** | _____/_____/_____ | **12/31/**_____ |
| **Pro-Rated for Mid-Year Enrollees?** | ☐ As of Plan Start Date<br>☐ As of Most Recent Quarter<br>☐ Other: _____ | ☐ As of Plan Start Date<br>☐ As of Most Recent Quarter<br>☐ Other: _____ |
| **Elect Runout Period:** | ☐ No<br>☐ Yes **>>**<br># of Days: _____ (Max 180 days)<br>End Date: ___/___/_____ | ☐ No<br>☐ Yes **>>**<br># of Days: _____ (Max 60 days)<br>End Date: ___/___/_____ |
| **Employer Contribution Amount: $** | | |
| **Frequency of Employer Contributions:**<br>*(When $ are made available to Employees)* | ☐ Annual/One Time:<br>Date of Contribution: ___/___/_____<br>☐ Per Payroll<br>☐ Monthly<br>☐ Other | ☐ Annual/One Time:<br>Date of Contribution: ___/___/_____<br>☐ Per Payroll<br>☐ Monthly<br>☐ Other |
| **Runout for Terminated Participants:** | ☐ End of Benefit Plan Runout<br>☐ Days after Eligibility End Date:<br>Enter # of Days: _____ | ☐ End of Benefit Plan Runout<br>☐ Days after Eligibility End Date:<br>Enter # of Days: _____ |
| **# of Contributions in 12-mo plan year:** | | |
| **Employer Contribution Dates:** | 1st Contribution Date: ___/___/_____<br>2nd Contribution Date: ___/___/_____<br>Last Contribution Date: ___/___/_____ | 1st Contribution Date: ___/___/_____<br>2nd Contribution Date: ___/___/_____<br>Last Contribution Date: ___/___/_____ |
| **Allow Online Enrollment** | ☐ No<br>☐ Yes >> Open Enrollment Dates:<br>___/___/____ to ___/___/____ | ☐ No<br>☐ Yes >> Open Enrollment Dates:<br>___/___/____ to ___/___/____ |
| **Funding** (funding method will default to ACH Debit unless indicated otherwise) | | |
| **Funding Type** (select one per account):<br>*When you are providing funding to TASC* | ☐ Contribution Schedule *(must match frequency selected for employer contribution dates)*<br>☐ Point of Disbursement[1]<br>☐ Custom/Other<br>*(Indicate in special instructions)* | ☐ Contribution Schedule *(must match frequency selected for employer contribution dates)*<br>☐ Point of Disbursement[1]<br>☐ Custom/Other<br>*(Indicate in special instructions)* |

[1]*If Point of Disbursement (Claims Based) Funding, POD Addendum and Pre-fund is required.*

## DOCUMENTS ONLY

☐ **Premium Only Plan (POP)** ☐ **Plan Only HSA**

☐ **Self-Administration FSA** ☐ **Self-Administration HRA**

## Premium Only Plan (POP) – Plan Details

Complete **"Section 125 Plan Document Premium Benefits," Participant and Eligibility Requirements,** and **Additional Eligibility Requirements** under General Information-Universal Benefit Account section.

| **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | _____/_____/_____ |
|---|---|---|---|
| **Do you currently offer an HSA?** ☐ No ☐ Yes | | >> ***If yes***, contributions are: ☐ Pretax under a Cafeteria Plan ☐ Post-Tax | |

## Plan Only HSA – Plan Details

Complete **"Section 125 Plan Document Premium Benefits," Participant and Eligibility Requirements,** and **Additional Eligibility Requirements** under General Information-Universal Benefit Account section.

| **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | _____/_____/_____ |
|---|---|---|---|

## Self-Administration FSA – Plan Details

***Select all benefits that apply:***

| | |
|---|---|
| ☐ Healthcare FSA | ☐ Limited Purpose Healthcare FSA (LPFSA) |
| ☐ Dependent Care FSA | ☐ Healthcare Premium (NESP) Reimbursement Account |

| **Plan Start Date:** | _____/_____/_____ | **Plan End Date:** | _____/_____/_____ | **ERISA Plan #:** | |
|---|---|---|---|---|---|

| | **Healthcare FSA** | | **Limited Purpose Healthcare FSA** | | **Dependent Care FSA** | | **Healthcare Premium (NESP) Reimbursement Account** | |
|---|---|---|---|---|---|---|---|---|
| **Annual Election** | Minimum *(if applicable):* $_____ | Maximum Contribution: $_____ | Minimum *(if applicable):* $_____ | Maximum Contribution: $_____ | Minimum *(if applicable):* $_____ | Maximum Contribution: $_____ | Minimum *(if applicable):* $_____ | Maximum Contribution: $_____ |
| **Carryover** ($500 max) | ☐ Yes | Amount: $_____ | ☐ Yes | Amount: $_____ | N/A | N/A | N/A | N/A |
| **Grace Period** (75-day max) (not available for plans with Carryover) | ☐ Yes | # of Days: _____ End Date: _____ | ☐ Yes | # of Days: _____ End Date: _____ | ☐ Yes | # of Days: _____ End Date: _____ | ☐ Yes | # of Days: _____ End Date: _____ |
| **Runout Period**[1] *(default 90 days after Plan End Date)* | ☐ Yes | # of Days from Plan Year End: _____ Runout End Date: _____ | ☐ Yes | # of Days from Plan Year End: _____ Runout End Date: _____ | ☐ Yes | # of Days from Plan Year End: _____ Runout End Date: _____ | ☐ Yes | # of Days from Plan Year End: _____ Runout End Date: _____ |

**Terminated Participant's Eligibility End Date:**
Select the plan eligibility end date for the last day a terminated participant may incur expenses.

| **Eligibility End Date** | ☐ Termination Date<br>☐ End of the Month of Termination<br>☐ Last Payroll Date *(Full Coverage Only)*<br>☐ End of Month Paid Coverage Ends *(Limited Coverage Only)* | ☐ Termination Date<br>☐ End of the Month of Termination<br>☐ Last Payroll Date *(Full Coverage Only)*<br>☐ End of Month Paid Coverage Ends *(Limited Coverage Only)* | ☐ Termination Date<br>☐ End of the Month of Termination<br>☐ Last Payroll Date<br>☐ End of Plan Year *(Dependent Care Requires Spend Down Amendment)* | ☐ Termination Date<br>☐ End of the Month of Termination<br>☐ Last Payroll Date |
|---|---|---|---|---|

| **Terminated Participant Coverage for Healthcare FSA or LPFSA:** Select the plan coverage option for terminated participants. | |
|---|---|
| ☐ **Full Coverage** after termination<br>☐ **Limited Coverage** after a terminated participant's paid coverage period ends (coverage paid through date) >> | ***If Limited Coverage,*** select the plan coverage paid through date:<br>☐ Termination Date<br>☐ End of the Month of Termination<br>☐ Last Payroll Date |
| **Runout Period for Terminated Participants**[1] | ☐ End of Plan Runout ☐ _____ Days after Eligibility End Date |
| **Offer Employer-Sponsored Group Health Insurance to Employees:** | ☐ Yes ☐ No |

[1]***IRC §125:*** *All benefits under a single IRC §125 plan must have the same eligibility and runout rules.*

## Self-Administration HRA – Plan Details

| | |
|---|---|
| **ERISA Plan #:** | |
| **Runout for Terminated Participants:** | ☐ End of Benefit Plan Runout ☐ _____Days after Eligibility End Date |
| **Allow Rollover:** | ☐ Yes >> If elected, select one timing: ☐ After Runout End ☐ Day 1 of New Plan Year |
| | ☐ Available Balance (no Maximum) |
| | ☐ Maximum Rollover (List): _____ |
| | ☐ % of Available Balance (List): _____ |

| **Plan Start** *(HRA Plan Year should match the medical plan year, if applicable)* | **Plan Start Date** | **Plan End Date** | **Runout** (Max 365 days) |
|---|---|---|---|
| | _____/_____/_____ | _____/_____/_____ | _____ Days<br>End Date ___/___/___ |
| | *Note: Plans need not run on the calendar year (i.e., January 1 – December 31)* | | |

### HRA Benefit Account Offerings

| | |
|---|---|
| Health Insurance Carrier Name: | |
| Health Insurance Deductible Individual: | |
| Health Insurance Deductible Family: | |

### Participant and Eligibility Requirements

Select an Eligibility requirement below. If eligibility is required by class, complete Class and Division Designation Form.

☐ Eligibility requirements include participation in the named Health Insurance Plan; - **OR** –
☐ Eligibility requirements include (*select all that apply below*):

- ☐ Part-time employees working at least _____ hours of work per week will be included (maximum 29 hours)
- ☐ Current employees completing _____ months of service with the employer will be included (maximum 90 days)
- ☐ New employees completing _____ months of service with the employer will be included (maximum 90 days)

### Benefit Account Reimbursement Options for Standard HRA's (Group sponsored health insurance required) *(select all that apply)*

| | |
|---|---|
| ☐ Medical deductible | ☐ Dental |
| ☐ Prescription | ☐ Vision |
| ☐ Co-insurance | ☐ Ortho |
| ☐ Co-Pays | ☐ 213(d) (all qualified uninsured medical expenses – premiums excluded) |

### Plan Type *(select only ONE option)*

☐ Family Aggregate: Expenses can be shared by family members
☐ By Member: Embedded Deductible

### TASC HRA Plan Participant and Employer Responsibility

☐ Employee Pays First (no card option)

| **Individual HRA Deductible $** | | **Family HRA Deductible $** | |
|---|---|---|---|

| **HRA Reimbursement Schedule** | **Percentage** | **Dollar Amount Range** | **HRA Employer Reimbursed Amount** |
|---|---|---|---|
| | % | $ _____ - $ _____ | $ _____ |
| | % | $ _____ - $ _____ | $ _____ |
| | % | $ _____ - $ _____ | $ _____ |
| | % | $ _____ - $ _____ | $ _____ |
| | Maximum Reimbursement **per individual**: | | $ _____ |
| | Maximum Reimbursement **per family:** | | $ _____ |

## COMPLIANCE OFFERINGS

### ACA EMPLOYER REPORTING

Complete and submit stand-alone ACA Employer Reporting Purchaser Detail for Controlled Groups and Governmental Entities

| | |
|---|---|
| **Plan Start Date** *(must be a calendar year)*:<br>Please indicate the calendar year in which you want reporting to start | _____/_____/_____ |
| Health Insurance Renewal Date: | _____/_____/_____ |

**Employer Type *(Select One)***

- ☐ Single ALE (Applicable Larger Employer (one EIN)
- ☐ Aggregated ALE (more than one EIN)
- ☐ Non-ALE (under 50 full-time employees)

**Applicable Large Employer Status (ALE) *(Select One)***

- ☐ ALE with fully insured medical plan
- ☐ ALE with self-insured medical plan
- ☐ Non-ALE with self-insured medical plan (1094B and 1095B Filing)
- ☐ ALE with fully insured and self-funded plans running congruently

**Controlled Group**

| | |
|---|---|
| Please indicate if you are a member of any of the following (required):<br>• A Controlled Group of business entities under IRS Section 414(b) or (c);<br>• An Affiliated Service Group under IRS Section 414(m); OR<br>• An Arrangement Described under IRS Section 414(o) | ☐ Yes *(see below)* ☐ No |

**Government Entity**

| | |
|---|---|
| Are you a Government Entity that has reportable employees under more than one EIN number? | ☐ Yes *(see below)* ☐ No |

If you answered YES to either question above, please complete the information 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 Purchaser Detail must be submitted separately for each entity.

| Entity's Legal Name | Entity's EIN Number |
|---|---|
| | |
| | |
| | |
| | |

**Additional ACA Reporting Services *(fees apply)***

- ☐ Variable Hour Tracking

### FORM 5500 PREPARATION – Plan Details

**NOTE: This service offering is for stand-alone 5500 plans only, not for customers receiving 5500 preparations as part of another TASC offering.**

**Number of Health/Welfare Plans (100+ ees):**

**Enter below all Plan Numbers to be filed and checkmark the frequency of services - current and late** *(separate **Purchaser Details** and fees apply to each plan #):*

| Plan Number(s) *(if known)* | CURRENT Ongoing | CURRENT One-Time* | LATE One-Time* | Notes *(applicable years, quantity, etc.)* |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | |
| | ☐ | ☐ | ☐ | |
| | ☐ | ☐ | ☐ | |
| | ☐ | ☐ | ☐ | |
| | ☐ | ☐ | ☐ | |

***Enter additional Plan Numbers in special instructions box on last page.***

| | | |
|---|---|---|
| Is Entity Part of:<br>• A Controlled Group of Corporations under Code Section 414(b);<br>• A Group of Businesses/Trades under common control under Code Section 414(c); OR<br>• An Affiliated Services Group under Code Section 414(m)<br>***If Benefits/Premiums are NOT paid from a single source, a separate Purchaser Details is required.*** | ☐ Yes | ☐ No |

**Must complete the "TASC USA Addendum One-Time Form 5500" in addition to the TASC USA.*

## ERISA – Plan Details

| **Plan Start Date** | The ERISA contract will be effective the first of the month in which the Purchaser Details Form is received. |
|---|---|

| **Plan Information** ***(select all that apply; if No, leave blank)*** | **Yes** | **No** |
|---|---|---|
| Is Entity Part of:<br>• A Controlled Group of Corporations under Code Section 414(b)<br>• A group of Businesses/Trades under common control under Code Section 414(c); OR<br>• An Affiliated Services Group under Code Section 414(m) | ☐ | ☐ |
| Are benefits/premiums paid from a single source? (if no, separate Purchaser Details are required) | ☐ | ☐ |
| Are you considered an Applicable Large Employer (ALE) under the Employer Shared Responsibility Provision of the Affordable Care Act (ACA)? | ☐ | ☐ |
| Do you currently track employee hours to determine if any variable hour, part-time, or season employees are full-time employees for purposes of health plan eligibility? | ☐ | ☐ |
| Do you offer Medicare Part D Coverage?<br>***If Yes***, please select one of the following ☐ Credible ☐ Non-Creditable ☐ Both | ☐ | ☐ |
| Under PPACA, is your current Group Health Plan considered Grandfathered? | ☐ | ☐ |

***(ERISA Continued)*** **Please complete the following information:**

| A | B<br>Contract Year (mo/dd/yr) | C<br>Benefit Contract Written to Group (G) or Individuals (I) | D<br>Pre-Tax Benefit (Y/N) | E<br>Insurance Carrier or Service Provider Name | F<br>Is Benefit Self-Insured (SI) or Fully-Insured (FI) | G<br>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 ERISA Services** ***(additional fees may apply)***

| | |
|---|---|
| ☐ Medicare Part D Notice | ☐ Professional Services (billed hourly) |
| ☐ Additional Benefit Plans (9+) | ☐ Form 5500 Late Filing |
| ☐ Carrier Certificates of Coverage Attached to Plan Document | ☐ PPACA & ERISA Notices |
| ☐ Wrap Document – Individual / Separate Affiliated Employer | ☐ Other: |

## PCORI – Plan Details

| | | |
|---|---|---|
| **Plan Start Date:** | _____/_____/_____ | Plans ending between 1/1/2019 & 9/30/2019 have a 7/31/2020 filing deadline. All other plans no longer have this requirement. Please indicate the year in which you would like reporting to start. |

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

- ☐ A – Health Reimbursement Arrangement (HRA)
- ☐ B – TASC HRA Purchaser
- ☐ C – TASC Non-Excepted Health Flexible Spending Account (NEFSA) Purchaser
- ☐ D – Self-Insured Health Plan
- ☐ E – TASC Self-Administered HRA or NEFSA Purchaser

**Participant Counts**

| | |
|---|---|
| As of the first day of the FIRST month of the plan year: | |
| As of the first day of the FOURTH month of the plan year: | |
| As of the first day of the SEVENTH month of the plan year: | |
| As of the first day of the TENTH month of the plan year: | |

**INSTRUCTIONS FOR PARTICIPANT COUNT:**

**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 administer your HRA in the previous year, please provide the appropriate counts.

## NON-DISCRIMINATION TESTING – Plan Details

| | | |
|---|---|---|
| Controlled Group: Please indicate if you are a member of any of the following: (required)<br>• A Controlled Group of Business Entities under IRS Section 414(b) or (c);<br>• An Affiliated Service Group under IRS Section 414(m); OR<br>• An Arrangement Described under IRS Section 414(o) | ☐ Yes | ☐ No |

If you selected "Yes" in the above question, please provide a list of all other companies and incorporated business entities. 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.)

**NOTE:** In general, all employees under a Controlled Group of employer are considered when performing Non-Discrimination Testing

**Testing Options** *(select all that apply; fill in dates if applicable)*

| Yes | No | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | Do you need testing for a Premium Only Plan – Section 125 (POP)? | | | |
| | | Plan Start Date | _____ / _____ / _____ | Plan End Date | _____ / _____ / _____ |
| ☐ | ☐ | Do you need testing for a Healthcare Flexible Spending Account (FSA)? | | | |
| | | Plan Start Date | _____ / _____ / _____ | Plan End Date | _____ / _____ / _____ |
| ☐ | ☐ | Do you need testing for a Dependent Care Flexible Spending Account (FSA)? | | | |
| | | Plan Start Date | _____ / _____ / _____ | Plan End Date | _____ / _____ / _____ |
| ☐ | ☐ | Do you need testing for a Health Reimbursement Arrangement (HRA)? | | | |
| | | Plan Start Date | _____ / _____ / _____ | Plan End Date | _____ / _____ / _____ |
| ☐ | ☐ | Do you need testing for Self-Insured Medical Plans? | | | |
| | | Plan Start Date | _____ / _____ / _____ | Plan End Date | _____ / _____ / _____ |
| ☐ | ☐ | Do you need testing for Group Life Insurance? | | | |
| | | Plan Start Date | _____ / _____ / _____ | Plan End Date | _____ / _____ / _____ |

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 of an affiliated service.

## CONTINUATION OFFERINGS

| COBRA - Plan Details | | | |
|---|---|---|---|
| **Plan Start Date:** | _____/_____/_____ | Purchaser Details must be received by the 15th of the month prior to this start date. COBRA Addendum is needed if requested plan start date does not meet this requirement | |
| **Total # of Employees** (Pro-Rate for Part-Time): | | | |
| **Number of Takeover Qualified Beneficiaries (TQBs):** | | **Number of Employees Enrolled in Group Benefits Plan:** | |

**COBRA Benefit Account Offerings** ***(select all that apply)***

☐ Include Takeover Qualified Beneficiaries (TQBs). >> ***If selected***, please include TQB forms for each beneficiary

☐ Include additional Subsidiaries, Affiliates, Divisions, Locations or Classes under TASC COBRA. >> ***If selected***, complete boxes below and TASC will create sub-clients under the parent company.

| | NAME | SEPARATE | | NAME | SEPARATE |
|---|---|---|---|---|---|
| 1 | | ☐ | 3 | | ☐ |
| 2 | | ☐ | 4 | | ☐ |

**Qualifying Events (QE) -** When a COBRA Qualifying Event occurs, select when you would like the COBRA period to begin:

☐ First of the month, following the Qualifying Event ☐ Day after the Qualifying Event

☐ Other:

**Additional COBRA Services** ***(fees apply)***

☐ Carrier Notifications (PS EOS Required) ☐ Other:

| RETIREE BILLING – Plan Details | | |
|---|---|---|
| **Plan Start Date:** | _____/_____/_____ | Purchaser Details must be received by the 15th of the month prior to this start date. |
| Number of Participating Retirees: | | |

**Retiree Billing Account Offerings** ***(select all that apply)***

☐ Include Takeover Qualified Beneficiaries (TQBs). >> ***If selected***, please include TQB forms for each beneficiary

☐ Include Additional Subsidiaries, Affiliates, or Divisions under TASC Retiree Billing >> ***If selected***, complete boxes below:

| | NAME | SEPARATE | | NAME | SEPARATE |
|---|---|---|---|---|---|
| 1 | | ☐ | 3 | | ☐ |
| 2 | | ☐ | 4 | | ☐ |

**Qualifying Events (QE) -** When a Qualifying Event occurs, select when you would like the Retiree Billing period to begin:

☐ First of the month, following the Qualifying Event ☐ Day after the Qualifying Event

☐ Other:

**Additional Retiree Billing Services** ***(fees apply)***

☐ Carrier Notifications (PS EOS Required) ☐ Other:

| **FMLA - Plan Details** | | |
|---|---|---|
| **Plan Start Date:** | _____/_____/_____ | Plan must start on the 1st of the month. Purchaser Details must be received at least 5 business days before the requested start date. |
| Do you have employees currently on FMLA leave? | ☐ Yes ☐ No<br>**>> If *Yes***, enter # of employees on FMLA leave: | |
| Does your company policy run FMLA concurrent with worker's compensation and short-term disability plans? | ☐ Yes ☐ No | |
| Which method of reporting do you use for FMLA hours? | ☐ Manual reporting via online form<br>☐ Data *feed (via recurring file from your timekeeping system* | |
| Which 12-month FMLA tracking type does your company policy outline? | ☐ Rolling Backward ☐ Rolling Forward<br>☐ Calendar Year<br>☐ Plan Year with Start Date of _____ / _____ / _____ | |
| Identify each State you have a location in: | | |
| If you are subject to any State FMLA Leave Entitlement, list the States: | | |
| Do you have any locations that are not eligible for FMLA? | ☐ Yes ☐ No | |
| **Additional FMLA Services** ***(fees apply)*** | | |
| ☐ Eligibility and entitlement determination (free with TASC Suite) | ☐ Other: _____ | |

| **If reporting per location is required, please enter locations and contacts below:** | | |
|---|---|---|
| | **Location and Contact Name** | **Email Address** |
| 1 | | |
| 2 | | |
| 3 | | |
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| **SPECIAL INSTRUCTIONS FOR TASC (for any section above):** |
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