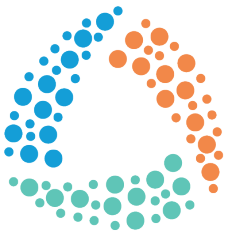


oca | Office of Compliant Administration

NEW GROUP APPLICATION

V20191

Employer New Group Application

Client Information

Name:		
DBA (if applicable):		
Company address:		
City:	State:	ZIP Code:

Federal Tax ID:	Date Incorporated:	Organization is operating pursuant to the state laws of:

Total # of **Eligible** Employees: _____ Est. # of **Enrolled** Employees: _____ Request Employee Meeting: □ Yes □ No

Organization Type

☐ C-Corporation	☐ Sub-Chapter "S" Corporation
☐ Professional Corporation	☐ Professional Association
☐ Partnership	☐ Sole Proprietorship
☐ Government Agency	☐ LLC - Limited Liability Company
☐ Non-Profit	☐ Other: _____

Plan Administrator(s)

The "Signatory Contact" should be the individual authorized to sign/execute the legal plan documents at the organization. All individual(s) listed below will be provided with Employer Administrative Access, EFT Notifications, Check Register Notifications, COBRA Event Notifications, and any other

Signatory Contact:	Title/Position:
Signatory Email Address:	Signatory Phone #: Ext:
Primary Contact:	Title/Position:
Primary Email Address:	Primary Phone #: Ext.

Broker Contact Information

Broker Name:	Broker Firm:
Broker Email Address:	Primary Phone #: Ext:
Requesting commission to be collected and remitted to broker: ☐ Yes ☐ No (if yes, additional paperwork will be required from the broker)	General Agency Name:
☐ By checking this box, I, the client, am providing authorization to the above named-broker to be granted access to our company's data located on the OCA Employer web portal. This includes temporary reactivation/extension of debit card transactions.	☐ By checking this box, I, the client would like to authorize the above-named broker to provide employee additions, changes and terminations directly to OCA within 30 days of the event.

Service(s) Selection (select all that apply)

- ☐ HRA (Health Reimbursement Arrangement)
- ☐ ICHRA (Individual Coverage HRA)
- ☐ QSEHRA (Qualified Small Employer HRA)
- ☐ FSA (Flexible Spending Account)
- ☐ HSA (Health Savings Account)
- ☐ COBRA
- ☐ Parking & Transit
- ☐ Retiree Billing
- ☐ Section 125 Premium Only Plan

Reimbursement Options (select all that apply)

- ☐ ClaimsExpress Reimbursement (If selected, OCA's debit card will only work for Rx expenses. All other expenses will automatically be reimbursed via direct deposit and/or paper check)
- ☐ ClaimsExpress Substantiation (Not recommend. If selected, please consult with an OCA Sales Manager to confirm if plan qualifies)
- ☐ Pay Provider Option (Coupled with HRA only- Not available with ClaimsExpress Reimbursement)
- ☐ Debit Card *(included at no charge w/HRA, FSA and/or Parking & Transit)*
- ☐ Direct Deposit Reimbursement

Paper Check Reimbursement

- ☐ **No** Paper Check Reimbursement (Paper Checks is a default reimbursement option unless otherwise noted here)

Association/Carrier Discounts(select all that apply)

- ☐ Current MEWA Subscriber
- ☐ Non-Profit Groups

Client Banking And Invoicing Set-up

Invoice Remittance Contact Person (if different than primary contact):

Mailing Address:

City:	State:	ZIP Code:

Invoice Payment Set-up *(method used to remit OCA monthly and annual fees)*

☐ Company Check ☐ EFT – use same account as below ☐ EFT – use alternate account

If payment is being remitted via an EFT (Electronic Fund Transfer), please note that monthly invoices will be drawn on the 15th of each month. Annual fees are drawn in the month of the renewal date of the Plan for each line of service that applies. Should the 15th of the month happen to fall on a weekend, bank holiday or a day in which OCA is closed the funds will be drawn the business day prior. A surcharge of $45 will be assessed to those accounts in which funds were not available at time of draw. Additionally, all lines of service for said Company will be placed on hold until the payment is able to be collected.

Employer EFT and Debit Card SET-UP *(Please attach copy of the voided check(s) or letter from the bank)*

□ We, authorize OCA to originate credit/debit entries to and from the below named account via EFT services provided by BMO/Harris Bank (descriptor is MED-I-BANK SETL MMDD). Prior to plan inception the employer account listed below will be subject to a **$1.00 pre-notification fee** from OCA's banking partner to confirm that the account is valid. We understand if banking information is not provided debit cards cannot be issued.

Bank Name:

Routing Number (9 digit #):	Account Number:

Check Reimbursement SET-UP *(method used to remit payment to employees via check)*

Starting check number OCA should be using *(this avoids overlap of check numbers if company is using this account for something other than OCA use. There is no need to order check stock, OCA uses our own supply)*: _____ *(required for set-up)*

Note: Reimbursement checks will be issued from the designated employer bank account provided on this form. Please keep in mind that OCA does not have signature authority on the employer account and therefore checks will first be sent to the employer for signature. As an option, the authorized signer can complete a "signature" form, which will allow OCA to capture the authorized signature and issue checks directly to the employee if preferred. This form is required when OCA issues checks directly to the provider.

Do you want reimbursement checks sent directly to the employee? □ No □ Yes (if selected, please complete the Check Reimbursement Signature section)

Check Reimbursement Signature *(if applicable)*

The signature captured here will be used for the sole purpose of releasing HRA/FSA/Commuter reimbursement checks, which will be then be mailed directly to the plan participant. The signed checks will only be issued to participants based on claims that have been submitted by the HRA/FSA/Commuter plan participants seeking payment for their eligible expenses. Whomever has signature authority on the company bank account that the HRA/FSA/Commuter reimbursement payments will be issued from, will need to sign inside all four boxes below (not on the line). This will ensure OCA can capture a valid signature to have printed directly on the reimbursement checks.

HRA (Health Reimbursement Arrangement)- IRS Section 105

Plan Effective Date: _____/_____/_____
(MM/DD/YEAR)

Plan No: 504 *(Unless otherwise specified, this will be the number referenced throughout the Plan Documents.)*

Alternate Plan No *(if applicable)*: _____

Do you currently have an HRA that you want OCA to handle the run-out period?

□ NO □ YES

If yes, OCA will need the claim history for prior plan year as well as confirmation of the HRA plan design.

Plan Duration

Please note: **The plan duration should match your plan's deductible schedule**. You may need to confirm this information with your carrier, as your plan renewal date is NOT always the same as when the deductible resets. If this is not filled out accurately resulting in the HRA being set-up incorrectly, OCA may charge an additional fee to make the necessary system corrections.

Plan Duration: □ Calendar Year or □ Plan Year – Runs _____/_____ thru _____/_____
(MM/DD) *(MM/DD)*

Linked Benefits Offered Under the HRA(s)

□ Health Insurance Name/Plan Type (i.e. QualCare Plan L, Horizon HSA Omnia, etc.): _____

□ Other (Dental, Vision):_____

Covered Expenses Under The Selected Benefit(s)

□ Applies to **In-Network Deductible** as credited on underlying Insurance EOB

□ Applies to **In & Out-of-Network Deductible** as credited on underlying Insurance EOB

□ Applies to **In-Network Coinsurance** as credited on underlying Insurance EOB

□ Applies to **In & Out-of-Network Coinsurance** as credited on underlying Insurance EOB

□ Prescription R*x* (OCA will accept R*x* stub)

□ Applies to expenses ABOVE U.C.R. levels credited on underlying Insurance EOB

□ Applies to Co-Pays (**if selected please choose which co-pays apply below**). *Please provide applicable SBC for co-pay info.*

□ R*x* Co-pay □ Office Co-pay □ ER Co-pay □ Hospital Co-pay □ Other Co-pay(s)_____

□ Applies to all 213(d) (this includes all eligible medical/dental/vision related services)

□ Applies to **Medicare Premium Reimbursement** (please consult with OCA to verify plan eligibility)

Contribution (When do funds become available)

□ Full HRA benefit available to "new hires" first day of eligibility

□ Pro-rate HRA benefit based on hire date.

Claims Run Out Period

Claims Run-Out Period will be 90 days after the plan year end unless otherwise noted here: _____

Benefit Order in which claims will be paid *(if applicable)*: □ HRA □ FSA Medical

Employer HRA Reimbursement Caps

□ ***Aggregated** □ ***Non-Aggregated**

Employee $	EE/Child(ren) $	EE/Spouse $	Family $

The $ amount listed above represents the TOTAL dollars that could be reimbursed under the HRA

Portion, if any, to be rolled over per Benefit/overall: $_____ %_____
(the dollar amount that is listed under the rollover benefit will be added on top of the HRA reimbursement caps listed above)

Reimbursement Structure

Please select the payout structure that applies to your company HRA. If not available, please provide plan details under the comment section.

□ Pay 100% of First Dollar

□ Pay _____% on the Dollar *(i.e. $100 claim – Employer covers 80%. HRA reimburses Employee $80)*

□ **Employee First Dollar Responsibility** (If selected, please indicate the employee 1st dollar responsibility in the boxes below. The $ amount listed in this section will be the amount the employee and/or dependent(s) must incur before having access to the HRA funds)

□ ***Aggregated** □ ***Non-Aggregated**

Employee $	EE/Child(ren) $	EE/Spouse $	Family $

Termination Requirements

If an employee that is participating with the HRA terminates employment *(voluntarily or involuntarily)* during the plan year, please indicate the last day in which they would be eligible to "submit" valid claims that were incurred prior to the termination date:

□ Same as Active Employees *(Employer elected run-out period)*
□ 90 Days from Date of Termination
□ Other: _____

Additional Comments

_____

_____

Definitions

***Aggregated (Non-Embedded)** means that the participant and/or any covered dependents claims are "lumped" together to meet the Employee First Dollar Responsibility or the maximum Reimbursement Cap.

***Non-Aggregated (Embedded)** requires each "member" to meet a "separate" dollar threshold applicable to the Employee Only tier with respect to the Employee First Dollar Responsibility or the maximum Reimbursement Cap.

Run out Period: The run-out period provides your employees an extension of time to receive the required documentation for claims incurred during the plan year and can submit them for reimbursement. This is ONLY for claims "incurred" during the plan year, not after.

FSA- IRS Section 125 (Health FSA, Dependent Care, POP)

Plan Effective Date: _____/_____/_____
(MM/DD/YEAR)

Plan No: 525 *(Unless otherwise specified, this will be the number referenced throughout the Plan Documents.)*

Alternate Plan No *(if applicable)*: _____

Is this a Take-Over FSA? Take-Over refers to FSA plans that are already enforce and you are requesting OCA to take over the administration of an existing FSA mid-year or to facilitate the run-out period from previous plan year.

□ NO □ YES

If yes, does the existing plan allow for the Grace Period (15th day of the 3rd month) or the $550 Roll-over Option? Check all that apply below.

□ FSA Grace Period □ DCA Grace Period □ $500 FSA Rollover

Plan Year Duration

Plan Duration: □ Calendar Year **or** □ Plan Year – Runs _____/_____ thru _____/_____
(MM/DD) *(MM/DD)*

Benefit(s) Selected Under Section 125 Plan

- □ Medical and Dental Expense FSA
- □ Dependent Care FSA
- □ Stacked Health FSA
- □ Limited Purpose Health FSA
- □ Major Medical
- □ Dental
- □ Vision
- □ Health Savings Accounts (HSA)
- □ Group Term Life Benefits
- □ Long Term Disability
- □ Short Term Disability
- □ Adoption Assistance
- □ Voluntary benefits such as Critical Illness, Hospital Indemnity and others
- Opt out (cash in lieu of electing health coverage)

Contributions

Health FSA:

Minimum $_____ Maximum $_____

Employer FSA contributions are limited to either $500 or an equal match of the employee's plan election. Employer contributions do NOT impact the employee annual IRS limit election.

Dependent Care FSA:

Minimum $_____ Maximum $_____

Dependent Care contributions during the calendar year cannot exceed $5,000, or $2,500 should the Participant be married and filing separately.

Plan Elections

Grace Period – This is automatically set to the 15 day of the 3rd month after the plan year ends unless opting out. The grace period relates to the period beyond the Plan's end date in which your employees may incur expenses and submit them for reimbursement. For example: on calendar plans with a standard grace period, employees have until March 15th to incur an expense and until March 31st to submit.

Grace Applies to: □ Health FSA □ Dependent Care

Roll-Over – This allows up to $550 to roll-over into the following Health FSA plan year.

□ Roll-Over Option

Electing the roll-over option allows participants to roll-over a maximum of $550 of unused FSA Medical funds into the new plan year without any impact to the annual election limits. This creates more flexibility and provides more time for participants to spend their flex dollars. If elected, you will no longer be able to offer the grace period on the Health FSA. **The roll-over option does NOT apply to Dependent Care. NOTE: We assume that terminating employees must elect COBRA to access a carryover from the prior plan year. Also, we assume that no carry over for use in any plan year in which the participant doesn't make a Health FSA salary reduction election.**

Eligibility Requirements

For the Health FSA to be considered an excepted benefit, employees must be eligible to enroll (although they don't need to elect) in the company-sponsored medical plan. Unless you select one of the following "non eligible" boxes below, **we assume that in addition to anyone who is not in an eligible class as defined above will be eligible.**

Not Eligible:

- □ Union Employees (unless the bargaining agreement provides for coverage)
- □ Non-resident aliens
- □ Independent contractors (only common law employees are permitted by law to participate)
- □ Leased Employees
- □ Temporary Employees

Coverage under the Health and Dependent Care FSA is effective:

Once the employees are eligible, they can begin participating in the plan:

- □ Date requirements are met (e.g. Date of Hire)
- □ First day of pay period following the date the employee becomes eligible
- □ First day of month following the date the employee becomes eligible
- □ First day of quarter following the date the employee becomes eligible
- □ First day of Plan Year following the date the employee become eligible
- □ Other: _____

Adopting Employers (If Applicable)

Please provide any adopting employers (affiliated groups) who will be adopting the Plan for the benefit of its eligible employees. Please note that any adopting employer must be part of the same controlled group.

Adopting Employers Name(s):

3. _____
4. _____
1. _____
2. _____

Claims Run Out Period For Active and Termed Employees

Active Employees: Claims Run-Out Period will be defaulted to 90 days after the plan year end unless otherwise noted here: _____

Termed Employees: If an employee that is participating with the FSA terminates employment (voluntarily or involuntarily) during the plan year, please indicate the last day in which they would be eligible to "submit" valid claims that were incurred prior to the termination date:

- □ Same as Active Employees (Employer elected run-out period)
- □ 90 Days from Date of Termination
- □ Other: _____

Payroll/Contributions Calendar

Please check off all applicable pay schedule(s). If your organization has more than one pay schedule (i.e. 10-month cycle employees vs. 12-month cycle employees) please indicate those additional pay cycles as well.

□ **Bi-Weekly (26 Pays)**

Please enter the 1st Pay Date that deductions will begin: _____

(OCA will post contributions the same day of the week following the initial bi-weekly schedule. If the post-date falls on a weekend and/or holiday, OCA will post the contributions prior to that date)

□ **Weekly (52 Pays)**

Please enter the 1st Pay Date that deductions will begin: _____

(OCA will post contributions the same day each week following the initial pay date (i.e. Every Tuesday). If the post-date falls on a weekend and/or holiday, OCA will post the contributions prior to that date)

□ **Monthly (12 Pays)**

Please enter the 1st Pay Date that deductions will begin: _____

(OCA will post contributions the same day each month following the initial pay date schedule. If the post-date falls on a weekend and/or holiday, OCA will post the contributions prior to that date)

□ Semi-Monthly (24 Pays)

Please send OCA your specific pay schedule each month in which deductions should be taken.

□ **Other:** _____

Contribution Billing Report Process

Based on your employer pay schedule, OCA will send the employer contact a monthly email indicating and showing the elections of each enrolled participant and what OCA believes should be deducted in their upcoming pay cycle. Employers will ONLY have to notify OCA if there are any changes to those contributions. This will result in a more efficient and timely process for employers and their employees. **OCA will still require employers to confirm the 1st payroll report for each plan year.**

It is important to remember that all changes in contributions (i.e. life event changes, terms, enrollments) must be communicated within 30 days of the event to OCA. Untimely communication of such changes may impact the participants correct usage of their benefits (i.e. over/under payments from their benefit).

Commuter- IRS Section 132 (Parking and Transit)

Plan Effective Date: _____/_____/_____
(MM/DD/YEAR)

Plan Duration: □ Calendar Year □ Plan Year – Runs _____/_____ thru _____/____
(MM/DD) *(MM/DD)*

Is this a Commuter Take-Over

Take-Over refers to Commuter plans that are already enforce and you are requesting OCA to take over the administration of an existing Commuter mid-year or to facilitate the run-out period from previous plan year.

□ No □ Yes (If yes, OCA will need the existing Parking & Transit plan elections and the employee's remaining balances.)

Benefit(s) and Contributions

□ **Parking**

Minimum $_____ Maximum $_____

The IRS has a monthly pre-tax contribution limit. Do you want to allow participants to contribute on a "post-tax" basis above the pre-tax contribution limit?

□ Yes - Maximum monthly election: $_____ □ No

□ **Transit**

Minimum $_____ Maximum $_____

The IRS has a monthly pre-tax contribution limit. Do you want to allow participants to contribute on a "post-tax" basis above the pre-tax contribution limit?

□ Yes - Maximum monthly election: $_____ □ No

Commuter Contribution Posting Process

When employees elect Parking and/or Transit they are pledging a monthly contribution through their payroll deductions. Since the ***monthly*** pre-tax election for Parking and/or Transit has I.R.S. imposed limits, payroll providers should be adjusting the contributions accordingly to ensure the monthly limit is not exceeded month to month considering that some months have varying payroll dates. *(i.e. one month may have two pay dates and another could have three.)*

Therefore, regardless of your company's payroll schedule, the purpose of this form is to schedule a set "posting date" for employee contributions pertaining to Parking and/or Transit benefits. This schedule will make their pledged contributions available for use through the MySource Debit Card. *(Posting means that OCA is applying the pledged amount on a designated date of your choosing.)*

Posting Schedule: ☐ Monthly (preferred method) ☐ Semi-Monthly

Date(s) to Post Funds:

- If monthly, please specify the date funds should become available to participants. _____
  (EX: If the 5th is written in, we will post the full month's contributions every month on the first business day prior to the 5th.)

- If Semi-Monthly, please specify the two dates in which funds should become available. _____
  (EX: If the 5th and 20th is written in, every month we will post half of the month's contribution on the first business day prior to the 5th and second half on the first business day prior to the 20th.)

Eligibility Requirements

The following class of employees is eligible to participate:

□ All □ Salaried Employee Only □ Hourly Employees Only □ Other: _____

The following employees are excluded from participation:

□ No Exclusions

□ Exclusions:

- □ Required to work _____ per week
- □ Employees under the age of _____
- □ Union Employees *(unless the bargaining agreement provides for coverage)*
- □ Non-Resident Aliens
- □ Other: _____

The service period employees must complete before being eligible to participate is as follows:

□ Date of Hire

□ Number of days after the Date of Hire: _____

□ Number of months after the Date of Hire: _____

Once the employees are eligible, they can begin participating in the plan:

□ Date requirements are met

□ First day of pay period following the date the employee becomes eligible

□ First day of month following the date the employee becomes eligible

□ First day of quarter following the date the employee becomes eligible

□ First day of Plan Year following the date the employee become eligible

□ Other: _____

Employee Termination Requirements

If an employee that is participating with the Commuter terminates employment (voluntarily or involuntarily) during the plan year, please indicate the last day in which they would be eligible to "submit" valid claims that were incurred prior to the termination date:

□ Same as Active Employees (Employer elected run-out period)

□ 90 Days from Date of Termination

□ Other: _____

Card Set-up *(Select all lines of services that apply)*

Please indicate which lines of service the card should be related to:

□ HRA □ FSA □ *Commuter (debit card will be authorized to work at all parking/transit terminal locations)

HRA Card Set up

Please identify the approved merchant(s) where the debit card will be permitted to use

□ IIAS RX Approved Pharmacies

□ Medical Providers (not available when ClaimsExpress Reimbursement and/or Pay Provider is selected)

□ Other_____

HRA Debit Card Payment Option:

□ Pay 100% of total card transaction (i.e. $100 swipe, HRA pays $100)

□ Percentage Split – Employer covers _____% of the total transaction amount (employee would be responsible for remaining balance)

□ Employee 1st dollar responsibility $_____(Single) $_____(EE+ Dep) Once satisfied the HRA/Debit Card will begin to pay

□ Per Transaction the debit card will pay (the employee is responsible for the difference):

$ _____Per RX *(regardless of RX Tier)* *$*_____ Per Office Visit $ _____Per ER Room Visit $ _____ Per Hospital

$_____Other

For additional options not listed above, please speak to your OCA Sales Manager

FSA Card Set up

□ Medical Providers (i.e. Hospital, Urgent Care, Lab)

□ IIAS Approved Pharmacies (RX and OTC eligible expenses (i.e. contact solution))

□ Dental Providers

□ Vision Providers

IRS Substantiation Rules and Co-pay Matching Set up

The Internal Revenue Service (IRS) regulations mandate that each and every electronic payment card payment be adjudicated and properly substantiated and that only those transactions that fit squarely into very limited "auto adjudication" categories need no additional paper substantiation because they are self-substantiating. One of those "auto adjudication" options is "Co-pay matching". **Under IRS rules, if a plan participant swipes their benefit card for a "co-pay" associated with the company sponsored plan, the card transaction will automatically resolve, thus eliminating the need to submit documentation to OCA.**

Request: **Please provide OCA will all company sponsored co-pays**. If you offer multiple plans, please indicate which plan each participant is enrolled in. OCA will then associate those plan co-pays with each participant. This will allow the specific plan co-pays to automatically resolve without having to submit documentation.

Federal COBRA/State Continuation

Are you subject to Federal COBRA or State Continuation? □ Federal COBRA □ State Continuation

Federal COBRA is federally guided and impacts employers with 20 or more employees during 50% or more of the prior year's total accumulation of business days. Individual State laws may vary, so please verify before signing up for this line of service.

COBRA Set up

OCA Start Date: _____/_____/_____
(MM/DD/YEAR)

Is this a takeover from another COBRA vendor? □ Yes □ No

Are there currently ACTIVE COBRA participants that OCA need to be aware of? □ Yes □ No

Are there currently QUALIFIED BENEFICIARIES within their election period? □ Yes □ No

Do **INITIAL NOTICES** need to be sent? □ Yes □ No

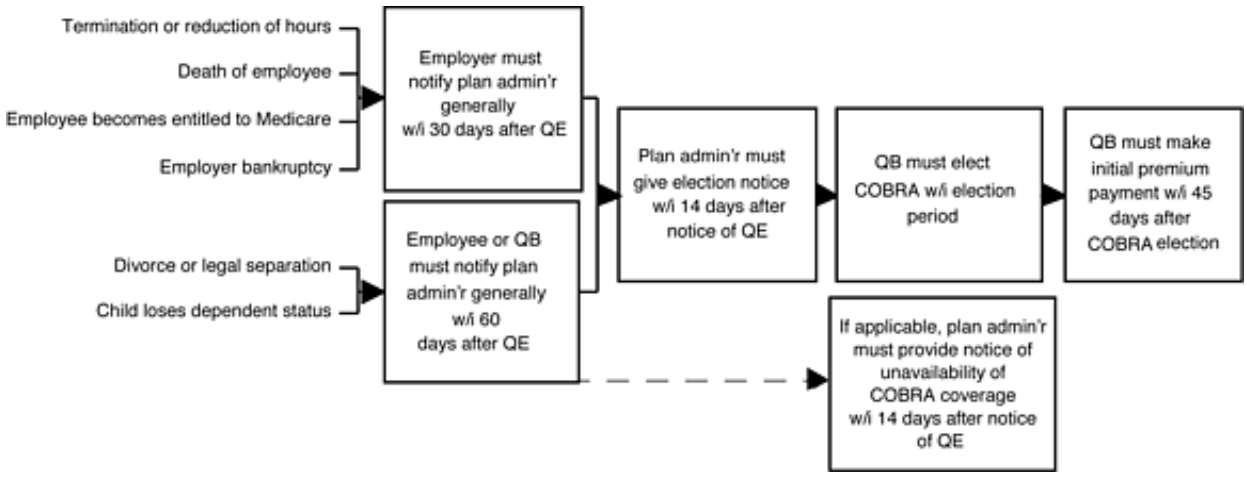
If yes, please send to: □ All Active Eligible Employees □ New Enrollments Only

General Federal COBRA Rules (may not apply for groups subject to State Continuation rules)

Below are group plans generally subject to Federal COBRA. The list is NOT exclusive and other group plans may or may not be subject to Federal COBRA.

- Health Plans
- Dental Plans
- Health FSAs
- Cancer Policies
- Wellness Programs
- Employee Assistance Plans
- Drug or Alcohol Treatment Programs and Health Clinic
- Self-Funded Health Plans
- Vision Plans
- HRAs
- Prescription Drug Plans
- Discount Programs

Below is a snapshot of the COBRA Election process:



Medical Plan Information (Additional Medical Plans Can Be Added on subsequent pages)

□ **MEDICAL** Name of Carrier _____ Is the medical plan: ☐ Fully Insured ☐ Self-Funded

Group #: _____ Effective Date: _____/_____/_____ Ending Date: _____/_____/_____
(MM/DD/YEAR) *(MM/DD/YEAR)*

Total MONTHLY EMPLOYER Rates ***(w/out 2% fee included)***:

Employee $	**EE/Child(ren) $**	**EE/Spouse $**	**Family $**

When an Employee is terminated, what is the last day of active Medical coverage:

□ Last day of the Month in which they were terminated
□ Date of termination
□ Other: _____

Health Reimbursement Arrangement (HRA) Plan Information (if applicable)

□ **HRA** Name of Carrier _____ (if different then OCA, please send HRA SPD)

Effective Date: _____/_____/_____ Ending Date: _____/_____/_____
(MM/DD/YEAR) *(MM/DD/YEAR)*

Current Annual HRA Benefit Dollar Threshold:

Employee $	**EE/Child(ren) $**	**EE/Spouse $**	**Family $**

Dental Plan Information (if applicable)

□ **Dental** Name of Carrier _____

Group #: _____ Effective Date: _____/_____/_____ Ending Date: _____/_____/_____
(MM/DD/YEAR) *(MM/DD/YEAR)*

Total MONTHLY EMPLOYER Rates ***(w/out 2% fee included)***:

Employee $	**EE/Child(ren) $**	**EE/Spouse $**	**Family $**

When an Employee is terminated, what is the last day of active Dental coverage:

□ Last day of the Month in which they were terminated
□ Date of termination
□ Other: _____

Vision Plan Information (if applicable)

□ **Vision** Name of Carrier _____

Group #: _____ Effective Date: _____/_____/_____ Ending Date: _____/_____/_____
(MM/DD/YEAR) *(MM/DD/YEAR)*

Total MONTHLY EMPLOYER Rates ***(w/out 2% fee included)***:

Employee $	**EE/Child(ren) $**	**EE/Spouse $**	**Family $**

When an Employee is terminated, what is the last day of active Vision coverage:

□ Last day of the Month in which they were terminated
□ Date of termination
□ Other: _____

Other Plan Information (if applicable)

□ **Other** Name of Carrier _____

Group #: _____ Effective Date: _____/_____/_____ Ending Date: _____/_____/_____
(MM/DD/YEAR) *(MM/DD/YEAR)*

Total MONTHLY EMPLOYER Rates ***(w/out 2% fee included)***:

Employee $	**EE/Child(ren) $**	**EE/Spouse $**	**Family $**

When an Employee is terminated, what is the last day of active coverage:

□ Last day of the Month in which they were terminated
□ Date of termination
□ Other: _____

Other Plan Information (if applicable)

□ **Other** Name of Carrier _____

Group #: _____ Effective Date: _____/_____/_____ Ending Date: _____/_____/_____
(MM/DD/YEAR) *(MM/DD/YEAR)*

Total MONTHLY EMPLOYER Rates ***(w/out 2% fee included)***:

Employee $	**EE/Child(ren) $**	**EE/Spouse $**	**Family $**

When an Employee is terminated, what is the last day of active Dental coverage:

□ Last day of the Month in which they were terminated
□ Date of termination
□ Other: _____

Employer HSA New Group Application

Client Information

Name:

DBA (if applicable):

Company address:

City:	State:	ZIP Code:

Federal Tax ID:	Date Incorporated:	Organization is operating pursuant to the state laws of:

Plan Administrator

Primary Contact:	Title/Position:
Primary Email Address:	Primary Phone #: Ext:

Broker Contact Information

Broker Name:	Broker Firm:
Broker Email Address:	Primary Phone #: Ext:
Requesting commission to be collected and remitted to broker: ☐ Yes ☐ No (if yes, additional paperwork will be required from the broker)	General Agency Name:

Health Savings Account Plan Information:

Plan Effective Date: _____/_____/_____ *(MM/DD/YEAR)*	Plan Deductible: _____/_____ *Single* *Family*

☐ Health Insurance Name/Plan Type (i.e. Aetna Bronze HSA, etc.): _____

Is this a take-over HSA from another administrator? ☐ No ☐ Yes (*If yes, employees may complete an HSA Transfer to move HSA funds)*

HSA Pricing

■ $2.95 Per Account Per Month

Who Will Pay the Monthly Fee?

☐ Employer ☐ Employee ***(OCA will debit the monthly fee directly from the employee's HSA account)***

Employer Signature

A signature from someone with authority to make changes to the organization's benefits and/or banking information is required. This signature indicates that you have had an opportunity to review this document in its entirety and that you agree to the terms and conditions set forth by OCA

Signature: _____ Effective Date: _____

Signature of a company authorized signer

EMPLOYERS – IMPORTANT INFORMATION

Ownership HRA/FSA Rules: Only "employees" can participate in a Cafeteria Plan and/or Health Reimbursement Arrangement (HRA) on a tax-favored basis. Thus, while partnerships, sole proprietorships and Sub-Chapter "S" Corporations may sponsor Cafeteria Plans, the following ***cannot*** participate on a tax-favored basis: sole proprietors, partners, and greater than 2% shareholders in Sub-Chapter "S" Corporations, as well as direct family members (spouses, siblings, parents, and children) of the greater than 2% owner. When the employer agrees to reimburse up to a specified amount of medical expenses incurred during a plan year for non-eligible participants, the compensation that the employer is providing under the Code to the "employee" is the value of medical coverage. The value of coverage is the fair market value of the coverage without regard to whether the employee utilizes the coverage in full. With rare exceptions, non-eligible participants are better suited to enroll in alternative coverage or establish an HSA account, if eligible. Please consult with your CPA for confirmation or further guidance as OCA does not render tax or legal advice.

Distribution of legal plan documents: Regardless of the line of service, each Employer is given a customized documentation package that OCA will provide during the implementation process. It is the sole responsibility of the Employer, as the legal Plan Administrator to notify OCA using the appropriate Employee Change of Status form within 60 days of a qualifying "life event" change. Also, OCA would like to remind our clients that it is solely the Employer's responsibility to distribute the Summary Plan Description to ALL of its participants (whether via a hard copy, email or intranet).

HRAs, COBRA and State Continuation: An Employer is entitled to bill COBRA participants 1/12th of the HRA maximum benefit (plus 2% administrative surcharge) unless the rollover option is selected. With the rollover option an actuary MUST be retained to determine COBRA premium for the HRA. The HRA is not available to participants selecting coverage under the NJ Dependent to Age 31 or most state continuation programs. Any unused COBRA contributions that are paid to the employer remain the employer's property at the conclusion of the Plan year run-out period. Conversely, Employers are responsible for funding the full amount a COBRA participant's claim through the HRA, even in cases when they haven't fully contributed their portion. An organization subject to COBRA is legally bound to offer the HRA.

Recommended Banking Option: To avoid unnecessary banking fees, we strongly recommend accounts used or set-up for the operations of any tax-favored plan be in a non-interest bearing general operating bank account.

Reenrollment Responsibilities: HRA groups will be automatically reenrolled each plan year unless notified of changes. FSA groups will be required to complete annual employee election forms along with the required employer reenrollment paperwork. OCA will reach out each open enrollment as a reminder of what is necessary and/or required.

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Authorized Signature:	**Print Name:**
Title:	**Date:**