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)
- ☐ FSA (Flexible Spending Account)
- ☐ COBRA
- ☐ Parking & Transit
- ☐ Retiree Billing
- ☐ HSA (Health Savings Account)
- ☐ Section 125 Premium Only Plan

Reimbursement Options (select all that apply)

- ☐ ClaimsExpress Reimbursement (If selected, OCA's mySource 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

A Deposit of $250 ($125 for POP Plans) made *payable to OCA* is required before we will initiate the processing of your Plan Documents. Once documents and/or employee booklets have been created, the deposit is non-refundable.

Company Name: _____

Client Banking And Invoicing Set-up (COBRA ONLY)

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

Bank Name:	
Routing Number (9 digit #):	Account Number:

Employer COBRA Premium Remittance ACH SET-UP *(Please attach copy of the voided check(s) or letter from the*

□ We authorize OCA to remit the COBRA monthly premiums via EFT to the employer bank account listed below. Premiums are remitted twice a month (if applicable). Should you prefer to receive the premiums via a check, please note there is a $2.00 fee per check issued. □ Company Check ($2.00 per check fee applied)

Bank Name:	
Routing Number (9 digits):	Account Number:

Signature

Signature: _____ Effective Date: _____

Signature of a company officer only

Print Name: _____ Effective Date: _____

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

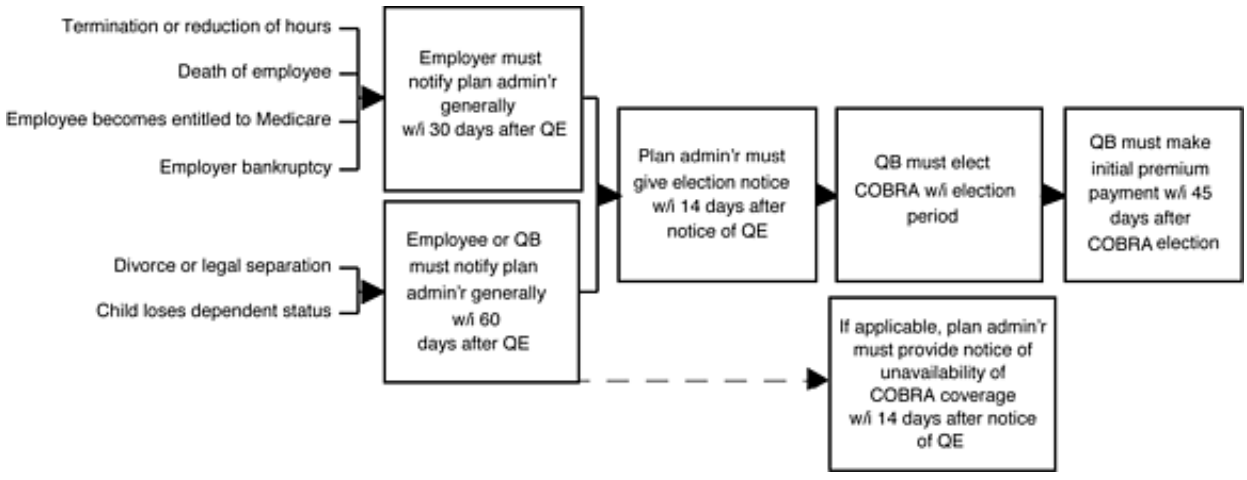
If yes, please send to: □ All Active Eligible Employees □ New Enrollments Only

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: _____

RETIREE BILLING

Retiree Billing

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

If retiree Billing is currently being administered by another vendor and OCA will be taking over this process:

Take-Over Effective Date: _____/_____/_____
(MM/DD/YEAR)

Are there currently **ACTIVE RETIREE** participants? □ NO □ YES

Are there currently **QUALIFIED BENEFICIERS** within their election period? □ NO □ YES

Do **INITIAL NOTICES** need to be sent? □ NO □ YES

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

Grace Period

Payment Remittance of 1st Payment due is within _____ days of electing.

Payment Remittance of each subsequent month due is within _____ days.

Payment Remittance for "short" payments due is within _____ days.

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 $

Qualifies Beneficiaries have _____ days to elect coverage.

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:_____

Coverage Expires:

□ Doesn't Expire
□ After _____ Months of coverage
□ Varies by Years of Service

If Participant becomes Medicare eligible, coverage expires:

□ On Date of Birthday
□ First Day of Birthday Month
□ Last Day of Birthday Month

RETIREE BILLING

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

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

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

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

□ Linked □ Unlinked

Current Annual HRA Benefit Dollar Threshold:

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

Children are termed at: _____ Students are termed at: _____

Coverage Expires:

□ Doesn't Expire
□ After _____ Months of coverage
□ Varies by Years of Service

If Participant becomes Medicare eligible, coverage expires:

□ On Date of Birthday
□ First Day of Birthday Month
□ Last Day of Birthday Month

NON-CORE HEALTH BENEFITS

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

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

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

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

Qualifies Beneficiaries have _____ days to elect coverage.

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:_____

Coverage Expires:

□ Doesn't Expire
□ After _____ Months of coverage
□ Varies by Years of Service

If Participant becomes Medicare eligible, coverage expires:

□ On Date of Birthday
□ First Day of Birthday Month
□ Last Day of Birthday Month

RETIREE BILLING

NON-CORE HEALTH BENEFITS

□ **VISION** Name of Carrier _____ Is the 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 $**

Qualifies Beneficiaries have _____ days to elect coverage.

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:_____

Coverage Expires:

□ Doesn't Expire
□ After _____ Months of coverage
□ Varies by Years of Service

If Participant becomes Medicare eligible, coverage expires:

□ On Date of Birthday
□ First Day of Birthday Month
□ Last Day of Birthday Month

ADDITIONAL HEALTH BENEFITS

□ Name of Carrier _____ Is the 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 $**

Qualifies Beneficiaries have _____ days to elect coverage.

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RETIREE BILLING

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:_____ **Coverage Expires:** □ Doesn't Expire □ After _____ Months of coverage □ Varies by Years of Service	**If Participant becomes Medicare eligible, coverage expires:** □ On Date of Birthday □ First Day of Birthday Month □ Last Day of Birthday Month

ADDITIONAL HEALTH BENEFITS

□ Name of Carrier _____ Is the 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 $

Qualifies Beneficiaries have _____ days to elect coverage.

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:_____ **Coverage Expires:** □ Doesn't Expire □ After _____ Months of coverage □ Varies by Years of Service	**If Participant becomes Medicare eligible, coverage expires:** □ On Date of Birthday □ First Day of Birthday Month □ Last Day of Birthday Month

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.

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.

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

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