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 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.

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.

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.

ICHRA (Individual Coverage Health Reimbursement Arrangement)

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)*: _____

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

□ NO □ YES

If yes, is the existing HRA plan design different?

□ NO □ YES

(If yes, OCA will need additional information on prior benefit 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)*

Covered Expenses Under the ICHRA Benefit(s)

□ Applies to **Individual Premiums for Medical Coverage** on underlying Minimal Essential Coverage (MEC) Policy

□ 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)_____

Contribution Availability

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

□ Pro-rate HRA benefit based on hire date. "If selected", please speak to OCA about pro-rated options

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

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: $_____ %_____

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.

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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