

Please Mark the Services Purchased: Reimbursement Accounts (FSA)

Section A – Employer Information

Company Name		DBA (Doing Business As)	Federal Tax ID Number - FEIN
Address		Requested effective date	
City		State	Zip
Telephone Number	Fax number	Nature of Business	
() -	() -		

Section B – Contact Information

Contact Type	Contact Name	Title	Phone	Fax	E-mail	Web Access	Monthly Invoice
Executive			() -	() -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary FSA			() -	() -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			() -	() -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			() -	() -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section C – Data Exchange

Encryption Method for confidential Information: PGP (www.pgpi.org/products/pgp/versions/freeware) WinZip (www.winzip.com)

In compliance with HIPAA Regulations, we require encryption of files submitted to CONEXIS or any files CONEXIS submits to our clients. If you use PGP to send files to CONEXIS, you will need to request our public key from submissions@CONEXIS.com. If you use PGP to receive files/reports, you will need to e-mail the text of your key to your New Business Analyst. **CONEXIS does not provide technical support for encryption software; please contact your network administrator for assistance.**

Section D – Broker Information

Internal Use Only

Broker Name	Broker of record for medical group? <input type="checkbox"/> Yes <input type="checkbox"/> No	Broker Code
Agency Name	Agency FEIN	
Address		
City	State	Zip
Phone	Fax	E-mail
() -	() -	

Section E – HIPAA Authorization

The following Named Contacts List identifies all individuals to whom CONEXIS may provide protected health information (PHI) in the performance of its duties as set forth in the Confidentiality Exhibit of the Administrative Services Agreement (Client may use additional pages if needed, provided they reference the Confidentiality Exhibit and the effective date):

Name: _____ Name: _____ Name: _____

Section F – Employer Representative – Form completed by:

Name	Title	Phone Number
		() -

Type of Plan: Flexible Spending Commuter Benefits

Instructions: Please complete each applicable section of this form. If the employer is implementing a Flexible Spending Plan, complete the entire form. Please return this form with the New Business Application.

Section A – General Plan Information (All information provided in this section will be used to create the Plan Document)

Plan Name (e.g. ABC Inc. Cafeteria Plan, etc, ABC Inc. Flexible Benefits Plan, etc):

Plan Year Start Date: / /	Plan Year End Date: / /	ERISA Plan Number (e.g. 501,502)	SIC Code Category
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Employer entity (check one)
 C-Corporation S-Corporation[†] Partnership[†] Sole Proprietorship[†] Limited Liability Other
[†] Partners in a partnership, 2% shareholders in an S-corporation or Limited Liability Corp and sole-proprietors may not participate in a Cafeteria Plan

Original Effective Date of any Section 125 Plan: / /	Effective Date of Plan Document and SPD (if using own document, it is valid for 5 years): / /
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In which state is your company incorporated?	Benefits of a Cafeteria Plan may be elected for (check all pre-tax premiums that apply): <input type="checkbox"/> Health Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> Vision Insurance <input type="checkbox"/> Group-Term Life <input type="checkbox"/> Disability <input type="checkbox"/> Other
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Number of days an employee has to provide notification of a 'Qualified Life Status Change':	Will Dependent Care expenses incurred after employment ends be reimbursed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are employees required to automatically re-enroll for non-FSA benefits? (e.g. evergreen or rolling elections) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Run out Period : Defaulted to 90 Days unless otherwise stated.	Run out period for terminated employees (this period should match the run out period in the previous field).	Do you sponsor an HRA that is available to individuals who are eligible for your FSA plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your FSA plan offer a limited reimbursement option? <input type="checkbox"/> Yes <input type="checkbox"/> No
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How is your plan funded? <input type="checkbox"/> General Assets <input type="checkbox"/> Trust	Who is your COBRA Administrator	Do you wish to offer the CONEXIS Benefit Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wish to offer the 2 ½ Month Grace Period Extension? (additional fees apply) <input type="checkbox"/> Yes <input type="checkbox"/> No
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What is your percentage of Non-English Speaking Employees? %	Total number of benefit eligible employees:	Additional Adopting Employers (please separate by a semi-colon):
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Section B – Flexible Spending Account Information

<input type="checkbox"/> Medical Flexible Spending Account		<input type="checkbox"/> Dependent Care Spending Account	
Minimum Contribution Amount	Maximum Contribution Amount	Minimum Contribution Amount	Maximum Contribution Amount
\$	\$	\$	\$
Eligibility Waiting Period: <input type="checkbox"/> First of the Plan Year <input type="checkbox"/> First of the Month following (number of) <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Other		Eligibility Waiting Period: <input type="checkbox"/> First of the Plan Year <input type="checkbox"/> First of the Month following (number of) <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Other	
Who is eligible? <input type="checkbox"/> Full-time Employees <input type="checkbox"/> Part-time Employees <input type="checkbox"/> All		Who is eligible? <input type="checkbox"/> Full-time Employees <input type="checkbox"/> Part-time Employees <input type="checkbox"/> All	
Minimum hours worked required to be eligible:		Minimum hours worked required to be eligible:	
Plan Contributions: <input type="checkbox"/> Employee Contributions Only <input type="checkbox"/> Employer Contributions Only <input type="checkbox"/> Employer and Employee Contributions			
If Employer Contributions are applicable, they are made: <input type="checkbox"/> At the beginning of the Plan Year <input type="checkbox"/> Pro rata each pay period		If Employer Contributions are applicable, they are made for: <input type="checkbox"/> Medical Flexible Spending <input type="checkbox"/> Dependent Care	
If Employer Contributions are applicable, the amount per participant is: \$ for Medical Flexible Spending \$ for Dependent Care		Total participation from last year: Medical Flexible Spending Dependent Care	

Section C – Commuter Benefits

<input type="checkbox"/> Parking Reimbursement Account		<input type="checkbox"/> Transportation/Vanpool Account	
Minimum Contribution Amount: \$	Maximum Contribution Amount: \$	Minimum Contribution Amount: \$	Maximum Contribution Amount: \$
Eligibility Waiting Period: <input type="checkbox"/> First of the Plan Year <input type="checkbox"/> First of the Month following (number of) <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Other		Eligibility Waiting Period: <input type="checkbox"/> First of the Plan Year <input type="checkbox"/> First of the Month following (number of) <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Other	
Who is eligible? <input type="checkbox"/> Full-time Employees <input type="checkbox"/> Part-time Employees <input type="checkbox"/> All		Who is eligible? <input type="checkbox"/> Full-time Employees <input type="checkbox"/> Part-time Employees <input type="checkbox"/> All	
Minimum hours worked required to be eligible: Plan Contributions:		Minimum hours worked required to be eligible:	
<input type="checkbox"/> Employee Contributions Only <input type="checkbox"/> Employer Contributions Only <input type="checkbox"/> Employer and Employee Contributions			
If employer contributions are applicable, they are made: <input type="checkbox"/> At the beginning of the Plan Year <input type="checkbox"/> Pro rata each pay period		If employer contributions are applicable, they are made for: <input type="checkbox"/> Parking Accounts <input type="checkbox"/> Transportation/Vanpool Accounts	
If employer contributions are applicable, the amount per participant is: \$ for Parking Accounts \$ for Transportation/Vanpool Accounts		Total participation from last year: Parking Accounts Transportation/Vanpool Accounts	

Section D – Payroll and Claims Payment

Payroll frequency #1 (Check One)

Semi-Monthly Bi-weekly Weekly Monthly Other

1 st Pay date of Plan Year:	List period start and end dates for 1 st pay date:	Last pay date of Plan Year:	List period start and end dates for last pay date:
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Any pay periods skipped for any reason and, if so, which ones?

Payroll frequency #2 (Check One)

Semi-Monthly Bi-weekly Weekly Monthly Other

1 st Pay date of Plan Year:	List period start and end dates for 1 st pay date:	Last pay date of Plan Year:	List period start and end dates for last pay date:
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Any pay periods skipped for any reason and, if so, which ones?

Claim checks will be mailed to participants (24 hours after check register is issued to client): <input type="checkbox"/> Daily <input type="checkbox"/> Weekly	If Weekly, check register is e-mailed on: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday
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E-mail address of check register recipients (separate by a semi-colon):

Payroll Deduction Method: <input type="checkbox"/> File Transfer <input type="checkbox"/> Client enters via CONEXIS web site <input type="checkbox"/> Assumed	If deduction method is 'Assumed' who should receive the deduction reports?
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Employer Representative – This form was completed by:

Name	Title	Phone Number () -
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_____ (“Client”) elects the banking option indicated below (check box):

Option 1 CONEXIS Initiates Automated Clearing House (ACH) Transfer of Funds from Client Bank Account to Custodial Account held by CONEXIS

Clients opting to offer FSA Benefit Card must choose banking option 1.

Client will provide CONEXIS with a copy of a voided check or MICR specification for each account as attestation of Client’s account from which CONEXIS will ACH funds. CONEXIS will provide Client with a check/ACH register according to the cycle chosen by the Client in the FBP New Client Profile 24 hours prior to initiating the ACH transfer of funds from Client Bank Account. Client will provide CONEXIS with the following information:

Bank Name
Bank Address (Street, City, State, Zip)
Bank Account Number
Bank Routing Number
Bank Contact Name
Bank Phone Number

Client hereby indemnifies CONEXIS for any ERISA compliance issues associated with this banking arrangement. CONEXIS will inform Client, and Client will inform CONEXIS of any bank account changes not less than 30 days prior to the intended effective date of the change. Checks/direct deposits will be released to participants upon verification that the ACH transfer of funds was successful. If sufficient funds have not been made available by the Client, reimbursements will be pended until sufficient funds are available.**

Option 2 CONEXIS issues checks drawn on Client bank account

Client will provide CONEXIS with the following information:

Bank Name
Bank Address (Street, City, State, Zip)
Bank Account Number
Bank Routing Number
Bank Contact Name
Bank Phone Number
Starting Check Number

If available, Client will provide a digitized signature file authorized at the Client’s bank. If a digitized signature is unavailable, CONEXIS will digitize the signature (i.e., the authorized signer will need to sign a piece of blank, white paper with a thick dark pen 3 times). CONEXIS will provide Client with a check/ACH register according to the cycle chosen by the Client in the FBP New Client Profile as notice of the amount of claim payments. CONEXIS will initiate an ACH transfer of funds from Client Bank Account for Direct Deposit items. Client manages cash balances and transfers funds to its account as necessary for checks to avoid CONEXIS’ issue of insufficient funded checks. Client bears sole responsibility for any fees imposed with respect to the account by the financial institution. Checks will be released to participants 24 business hours after the date CONEXIS provides Client with check/ACH register.**

Client will inform CONEXIS of any bank account changes not less than 30 days prior to the intended effective date of the change. Bank account changes will not be effective until CONEXIS has successfully tested new MICR specifications for new account.

Option 3 – Client Issues Participant Payments

CONEXIS will provide a register of claims processed according to the cycle selected by Client in the FBP New Client Profile. Client will reimburse participants.

Client acknowledges selecting Banking Option _____ above.

Approved by (Authorized Client Representative): _____
Signature

****If sufficient funds have not been made available, CONEXIS reserves the right to issue standard checks in lieu of ACH payments and/or hold checks until appropriate funding is received.**

INSTRUCTIONS: Please complete this form to authorize CONEXIS to debit your account automatically each week for your Electronic Funds Transfers of participant reimbursements. When completed, please return to:

CONEXIS

Sales

721 South Parker, Suite 300

Orange, CA 92868

Your original signature is required.

Company Information

Company Name		Today's Date
Telephone Number	E-mail Address	
Desired Transaction <input type="checkbox"/> Set Up <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Bank Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings Please enclose a voided check, if checking, or a deposit slip, if savings.	

Bank Information

Bank Name	Bank Telephone Number	Account Number
Bank Routing Number	Bank Address	City, State, Zip Code

Authorization Statement

I authorize CONEXIS and the Bank indicated to initiate debit entries automatically from the above account each week, in an amount not to exceed the total Electronic Funds Transfers issued to participants. This authority will remain in effect until I have either cancelled it in writing with 30 days notice or upon issuance of written notice from CONEXIS.

Authorized Signature

Print Name