



Employer Application Flexible Spending Account

Employer Information

Company Name: _____ Phone: _____
(Full and complete legal business name)

Street: _____ Fax: _____

City: _____ State: _____ Zip: _____

Employer's Taxpayer Identification Number: _____

State of incorporation: _____

Plan Sponsor Fiscal Year End Date: _____

Type of Entity:

C Corporation

S Corporation

Non-Profit

Sole Proprietorship

Partnership LLC

Union

Partnership LLP

Name of the representative of the parties who established or maintain the Plan:

Governmental Agency

Other: _____

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Flexible Spending Account.

The following affiliated employers will adopt this Flexible Spending Account as Participating Employers (if there is more than one, or if Affiliated Employers adopt this after the date the Adoption Agreement is executed, attach a list to this Adoption Agreement of such Affiliated Employers including their names, addresses and taxpayer identification numbers):

N/A

Name of Affiliated Employer(s): _____

Is this a controlled group (company owned by another company)?

Yes No

If yes, enter name of company owned by: _____

Contact Name: _____ Title: _____

Contact Phone: _____ Contact Email: _____

Broker Name: _____ Agency Name: _____

Broker Contact Phone: _____ Broker Contact Email: _____

Additional day-to-day contact if applicable:

Name: _____ Title: _____

Phone: _____ Email: _____

Plan Setup Information / Arrangement Options

On the line below, enter the 3-digit plan number (sometimes called the health and welfare plan number) the employer or plan administrator assigned to the plan. This 3-digit number, in conjunction with the employer identification number (EIN), is used by government agencies as a unique 12-digit plan identification number. Sterling needs this information so that we can assign a unique plan number to each plan we create for employers. This number will appear in your plan documents that we produce and send to you. It is important not to duplicate a plan number if it has been used for any other benefit plan (even one that has been terminated). Having an accurate plan number is critical for IRS form 5500 filing (if required). Once you use a plan number, continue to use it for that plan for all future filings with government agencies. Health and Welfare Plan Numbers should begin with 501 and increase with each subsequent Plan.

Health & Welfare Plan Number: _____

New FSA Renewal FSA Reinstatement of previously adopted Plan: _____

Original effective date: _____

Effective Date: _____

Plan Year - plan year means each 12 consecutive month period during which expenses can be incurred.

Plan Year Dates _____ to _____

The plan has a short plan year: Yes, the short plan year begins _____ and ends on _____
 No

Total number of employees in your company: _____

If you reach 20 employees or 50 employees prior to your next Plan renewal period, it is your responsibility to notify Sterling so we may add newly applicable COBRA or FMLA language to your Plan Documents.

Total number of FSA eligible employees in your company: _____

Section 125 Options

Will Employer establish a Premium Conversion Account for pretax payroll redirection of employee portions of group premiums? If so, select the types of insurance plans offered to employees through the Premium Conversion Account:

- | | | |
|---|---|---|
| <input type="checkbox"/> EMPLOYER GROUP MEDICAL | <input type="checkbox"/> EMPLOYER VISION | <input type="checkbox"/> EMPLOYER DISABILITY |
| <input type="checkbox"/> EMPLOYER DENTAL | <input type="checkbox"/> EMPLOYER GROUP TERM LIFE | <input type="checkbox"/> HEALTH SAVINGS ACCOUNT (HSA) |

Do you want to include a Limited Purpose or Post Deductible FSA? If so, check the box below to indicate which type you will set-up:

- Limited Purpose FSA for dental and vision expenses only for the entirety of the Plan Year
- Post Deductible FSA to allow for medical expenses after the health plan statutory deductible has been met
(Dental and vision expenses will be eligible until the participant submits evidence that the deductible has been satisfied. At this time, all Section 213(d) expenses will be eligible.)

Will you also offer the traditional FSA for participants who are not in your high deductible health plan?

- Yes No

Will Employer establish a separate dependent care plan (used for qualified daycare and/or elder care expenses)?

- Yes No

Will you establish a separate Individual Insurance Premium FSA (used for employee purchased, individually held insurance policy premium expenses)?

- Yes No

Section 132 Options

Plan Features:

- Contributions to pay for transportation in a commuter highway vehicle (i.e., vanpool with seating capacity of seven or more)
- Contributions to pay for qualified parking are permitted
- Contributions to pay for transit passes are permitted
- Contributions to pay for bicycle, bicycle improvements, repair and storage (100% company funded and not to exceed \$20 per month) Company contribution amount will be \$ _____
- Will the company make contributions to the Transit or Parking plan? If yes, indicate per pay period amounts:
 Transit \$: _____ Parking \$: _____

Eligibility Requirements

The following eligibility requirements apply (choose all that are applicable):

- Part-time employees completing _____ hours of work per week will be included (maximum of 25 hours)
- Seasonal employees completing _____ months of work within a year will be included (maximum of 7 months)
- Current employees completing _____ months of service with the employer will be included (maximum 36 months)
- New employees completing _____ months of service with the employer will be included (maximum 36 months)
- Do you have union employees under a collective bargaining agreement?
 No Yes
If yes, will they be eligible to participate?
 No Yes

Is there a minimum age requirement to participate?

No Yes

If yes, what age? _____

When will newly eligible employees be able to join the plan:

Immediately

First day of the calendar month

First day of the plan year

Plan Contributions

Minimum contribution to Healthcare FSA _____ Maximum annual election _____

Minimum contribution to DCA _____

Will employer contribute to the Healthcare FSA? No Yes

If yes, what amount will employer contribute to each employee per pay period? _____

Will employer permit cash in lieu of benefits? No Yes

Will employer impose limitations? _____

If the annual election is not equally divisible by the number of contributions for the Plan Year, will the employer

Round the payroll contribution up and reduce the final contribution to meet the annual election

Round the payroll contribution down and increase the final contribution to meet the annual election

Contribution Frequency

Number of contributions within plan year: _____

Payroll frequency - Select all that apply:

Monthly Semi-monthly: 15/last, 5th/20th, Other Biweekly Weekly

First pay period contribution date of the plan year for each payroll cycle: _____

If your pay date falls on a weekend or holiday, is it moved to the previous or next business day?

Please provide a payroll calendar for each payroll cycle if you have one available to you.

FSA Grace

Will Employer allow a 2.5 month extension to incur claims?

Yes No

FSA Run-Out

A claim may be submitted up to (choose one) 30 60 90 days after (referred to as a run-out period):

The end of the Coverage Period The end of each Plan Year Other: _____

FSA Debit Cards

Debit cards are \$1.00 per participant. One card per participant will be issued automatically when the account is set-up and additional cards can be ordered for dependents that are covered under the Plan. For each participant, the first two cards are free. Any additional cards will incur a fee of \$10 each. Replacement for lost or stolen cards will also incur a fee of \$10. These fees will be billed to the employer who may recoup the cost from the participant at their discretion. Additionally, please be advised that the debit cards will be preprogrammed based on selected criteria, however, the card's auto-adjudication may not be 100% accurate in all cases. If a debit card is used fraudulently, the employer has the right to require the participant to repay the Plan. When participants that have debit cards terminate employment, they will be de-activated upon notification from you of the termination. Employees who are terminated must file paper claims to access FSA funds available to them through the run-out or COBRA period.

Please check the box below to indicate if you want debit cards for your employees.

Debit Card

Please initial here to confirm your full understanding of the debit card process and fees: _____

No Debit Card

Administrative Options

COBRA Administration:

I would like Sterling Health Services Administration to administer the FSA funds for terminated employees.

I prefer to administer the COBRA as it applies to our FSA plan.

Nondiscrimination Testing:

I would like Sterling Health Services Administration to conduct nondiscrimination testing as it applies to our FSA plan. Nondiscrimination testing will take place within the first and last quarters of my Plan Year. I understand that I will have to provide additional reports to Sterling Health Services Administration if I select this option. If my plan is found to be discriminatory, I understand that I will need to make the necessary adjustments to the elections to ensure that the plan becomes non-discriminatory.

I prefer to conduct the discrimination testing as it applies to our FSA plan.

Employer Fees Paid to Sterling

Sterling HSA Sales Representative complete the following information regarding employer fees paid to Sterling based on the FSA plan selected and associated pricing.

FSA plan one-time set-up fee: \$ _____

FSA monthly fee per participant: \$ _____

FSA plan annual renewal fee: \$ _____

Employer Funding & Contributions and Monthly Invoicing

All Plan reimbursements, debit card transactions (if applicable), and monthly invoicing will be withdrawn via an ACH transaction. To fund your company's FSA account, Sterling Health Services Administration will initiate debit entries from the account. By providing the information below, you are authorizing Sterling Health Services Administration and/or Fidelity National Information Services (debit card processor) to initiate entries to your checking/savings accounts at the financial institution listed below and, if necessary, initiate adjustments for any transactions credited/debited in error. All entries are related to the FSA accounts your company has established with Sterling Health Services Administration. This authority will remain in effect until Sterling Health Services Administration is notified by you in writing to cancel it in such time as to afford Sterling Health Services Administration and the financial institution named below a reasonable opportunity to act on it. **You must attach a copy of a voided check to this application as part of this process:**

I authorize the use of this account for:

All transactions Plan reimbursement and debit card transactions Monthly invoicing

Financial Institution Name _____

Financial Institution Routing Number _____

Account Number for Debits to Fund FSA Account _____

I authorize the use of this account for:

All transactions Plan reimbursement and debit card transactions Monthly invoicing

Financial Institution Name _____

Financial Institution Routing Number _____

Account Number for Debits to Fund FSA Account _____

Application Agreement / Signature

We, the undersigned employer, affirm the accuracy of this application and acknowledge that this application can be relied upon for the preparation of the Flexible Spending Account with Sterling Health Services Administration and may be used in preparation of the Summary Plan Description and/or Plan Document. We also agree to indemnify Sterling Health Services Administration and hold Sterling Health Services Administration harmless against any and all loss, damage or lawsuits brought against Sterling Health Services Administration to recover benefits under the plan, unless such actions arise out of the willful act or negligence of Sterling Health Services Administration.

Dated this _____ day of _____, 20_____

Employer: _____

By: _____ Title: _____