

SelectAccount®

Premium Only Plan or TaxSaver Health Options PRA PLAN DESIGN GUIDE

For Office Use Only

SelectAccount Group Number _____

Enrollment Specialist _____

Please complete this form and return to SelectAccount 45 days before your effective date so we can properly administer your plan.

If you have any questions, please call our Group Leader Line at 1-888-460-4013 or our Agent Service Line at 1-888-460-4015. When complete, either fax this form to (651) 662-1180 or toll-free at 1-866-231-0214, or mail it to SelectAccount, PO Box 64193, Saint Paul, MN 55164. **Incomplete forms will cause delays setting up your plan.**

I. EMPLOYER INFORMATION

Employer's Name _____

Employer's Street Address _____

City _____ State _____ Zip Code _____

Employer's Tax I.D. Number (required) _____ Nature of Business _____

Type of Corporation S Corporation* C Corporation Partnership* Sole Proprietor*
 Political Subdivision/Church LLC* Other _____

**2% or more shareholders of an S Corporation, along with partners in a partnership, sole proprietors and members of an LLC or PLLP cannot participate in a cafeteria plan.*

Number of Employees Eligible for Plan (required): _____

Person Responsible For Authorization of Plan Design:

Name _____ Title _____

Phone Number () _____ Fax Number () _____

Email Address _____

Main Contact Person _____ Title _____

Phone Number () _____ Fax Number () _____

Email Address _____ To add more contacts, complete the Group Contact Change form.

II. AGENT INFORMATION

Agent Name (if applicable) _____

Agent Code _____ Agent Phone _____

Agency Name (if applicable) _____

Agency Code _____ Agency Phone _____

III. PLAN INFORMATION

Plan Year

Start date _____ End date _____

Plan Options (select one of the following options)

- Premium Only Plan (POP) - employer sponsored health plan. Go to section IX. Additional Required Information - do not complete the other sections.
- TaxSaver Health Options Premium Reimbursement Account (PRA) - Pre-tax funding vehicle for any individual health plans or other individual insurance premiums. To be used by groups who do **not** sponsor a group health plan. Continue to Section III. Administrative Information.

TaxSaver Health Options PRA Important Information

- Groups must be careful to avoid establishing an ERISA plan because then HIPAA nondiscrimination, COBRA, and other federal laws apply.
- Employee participation must be voluntary.
- No employer contributions permitted.
- Limited employer functions, without endorsing the plan.
 - Permit the insurer to publicize the program to employees.
 - May allow insurer presentations in the workplace and act as an intermediary, however, the employer should not answer employee questions about the insurance coverage.

IV. ADMINISTRATIVE INFORMATION

Health Plan Administration

Health Plan Carrier Name (if applicable) _____

Eligibility - required for plan documents (generally matches health plan eligibility)

Employees must work at least _____ hours per week to be eligible

Waiting period (select **only one**): None 30 days 60 days 90 days

Benefits will begin on:

- First of the month following date of hire
- Date of hire (only available with "none")
- First day after completion of the waiting period (not available with "none")
- First of the month after completion of the waiting period (if this falls on the first of the month, benefits begin that month)
- Other _____

How long do employees have to make their election after they become eligible to participate? _____
(Select Account will assume 30 days if not indicated)

Runout Period

The runout period is the deadline for participants to submit claims for the previous plan year. All eligible claims must be received by the end of the runout period.

The suggested runout period is 3 months from the end of the plan year.

Please indicate the length of the runout period for active employees: _____ (months)
(Length of runout period must be indicated in whole and/or half month increments. Half months equate to 15 days.)

Please indicate how you would like runout to apply to terminated employees (select **only one**)

- The runout period noted above begins at termination date (recommended)
- Same as active employees

V. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

- Group Online Service Center. Employer will enroll participants online using the Group Online Service Center at www.selectaccount.com.
- Electronic file

(Electronic enrollment file format requirements will be provided via email following the approval of the plan design guide.)

VI. PAYROLL INFORMATION

Please select one:

- The payroll contribution frequency is the same for all employees and is:
 - weekly bi-weekly monthly bi-monthly other _____
 Please indicate the first payroll date: _____

- The payroll contribution frequency differs by employee classification or location.

SelectAccount recommends submitting payroll data 2 business days prior to the payroll date.

FSA PAYROLL REPORTING INFORMATION

SelectAccount is required to post payroll deduction information throughout the year for all employees choosing to participate in the plan. Funds should **not** be sent with any deduction information.

We offer two options for sending us your payroll deduction data:

- Electronic File** *(recommended)*: This option requires employers to create a file using SelectAccount format requirements. This option is required for employers with 50 or more employees and is recommended for all employers. (Contact the group leader line for file format requirements)
- Paper Report**: This option is a report that the employer creates each payroll date and sends to SelectAccount via fax or mail. This option may only be used for employers with fewer than 50 participants.

VII. REIMBURSEMENT PROCESSING

Please indicate the contact person for reimbursement payments, if different from main contact person:

Name _____ Title _____
 Phone Number () _____ Fax Number () _____
 Email Address _____

Please indicate how you wish to be notified regarding claim reimbursement amounts: *(select only one)*

- Fax Number () _____
- Email Address _____

Please indicate your preferred claim reimbursement report format: *(select only one)*

- Standard Report (lists each employee, by location)
- Total Only Report (lists totals only, by location)

Automated Clearinghouse Information (completion of this section is mandatory)

I hereby authorize SelectAccount to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided to SelectAccount for initiation of this procedure.

Bank Name _____

Type of Account: Checking Savings

Bank Account Number _____

Bank ABA Number _____

(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

VIII. ADMINISTRATIVE TIPS:

ONLINE ACCESS: www.selectaccount.com

With SelectAccount, your employees have access to a powerful tool for managing their PRA. By registering with selectaccount.com, your employees can:

- Enroll in direct deposit
- Create and view a customized statement
- View recent claims or reimbursement requests
- Manage their personal profile

You can also access forms and enrollment materials at www.selectaccount.com

LOCATIONS: Multiple SelectAccount locations are available for 51+ groups only. If you want multiple SelectAccount locations, please complete and attach the Location Addendum (F8928). Locations must be the same across all products administered by SelectAccount. If you wish to have different ACH accounts by location, please complete the Group ACH Form (X9055).

ACCOUNT FEES: Participant fees are billed monthly via mail and are payable by check only. You will receive one bill for the entire group including the billed amount for each location (if applicable).

PLAN DOCUMENTS: SelectAccount will be preparing your Plan Document and Summary Plan Description (SPD). The documents will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.

IX. SIGNATURES

It is agreed that necessary information concerning current and future employees and/or their dependents who participate in this Plan and employees whose participation is to be changed or discontinued shall be provided to SelectAccount on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date _____

Printed Name _____ Title _____