Flex Plans Employer Set-Up Form

Producers: Please complete this form and submit an electronic copy to your Health Plan along with the new business or renewal paperwork.

Health Plans: Please return a copy of this form to fpsales@flexiblebenefit.com.

The Flex Implementation Team will reach out to the Producer and/or the Employer to begin the implementation process after receiving a copy of this from from the Health Plan. For questions, please contact the Flex Implementation Team at 888-345-7990, Option 2.

Section 1 of 6: Requested Flex Plans (Please check all that apply.)

☐ **Flexible Spending Account (FSA)**
Includes health care and dependent care FSA, POP, and 3 baseline Cafeteria Plan and FSA Dependent Care NDTs

☐ **Health Reimbursement Arrangement (HRA)**

☐ **Health Savings Account (HSA)**
Employer-based solution

☐ **Commuter Plan**
Transit & Parking Reimbursement

Premium Only Plan (POP)

☐ Stand-alone POP (Documentation Only)
Requires a $250 one-time fee with application

☐ POP with Testing (Documentation Included)
Requires a $350 first-year fee with application

Wrap Document Services

☐ One-time Wrap Document Preparation
Requires a $400 one-time fee with application

Bundled POP and Wrap Document Services

☐ POP without Testing and Wrap Document Preparation
Requires a $500 one-time fee with application

☐ POP with Testing and Wrap Document Preparation
Requires a $600 one-time fee with application

☐ **Non-Discrimination Testing (NDT)**
Stand-alone Compliance Service - includes 6 tests

Section 2 of 6: Health Plan Account Executive (Please complete in full.)

Name: _____

Email Address: _____

Telephone: _____

Section 3 of 6: Producer Information (If applicable, please complete in full.)

Brokerage Name: _____

Producer Name: _____ NPN: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email Address: _____

p: 888-345-7990 // f: 847-807-8006 // fpsales@flexiblebenefit.com
8770 W. Bryn Mawr Avenue, Suite 1290W, Chicago, IL 60631

EAF-PAR-0222

Section 4 of 6: Employer Information (Please complete in full.)

Company Name: _____
(Enter company name exactly as it appears on the most recent tax documents.)

Federal Employer ID No: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

The Employer/Organization entity is operating pursuant to the laws of the State of: _____

Primary Employer Contact Person: _____

Title: _____

Telephone: _____ Email Address: _____

Section 5 of 6: Organization Type (Please select only one.)

- ☐ Corporation
- ☐ Government Agency
- ☐ Sole Proprietorship
- ☐ Professional Corporation
- ☐ Sub-chapter S-Corporation
- ☐ LLC (Limited Liability Company)
- ☐ Partnership
- ☐ Professional Association
- ☐ Other: _____

For FSA, POP and HRA: Only employees can participate in this plan. Sole Proprietors, Partners in a Partnership, more than 2% shareholders of a Sub-chapter S-Corporation (including their spouses, children, grandchildren and parents of employees of the S-Corporation) Outside Directors, Limited Partners and Partners/Owners of an LLC cannot participate.

Section 6 of 6: Additional Information (Please complete in full.)

Requested Effective Date: _____ Number of Eligible Employees: _____

Does this employer currently have an in-force plan? ☐ Yes ☐ No

Is this employer being transferred (mid-year) from another Administrator? ☐ Yes ☐ No

Will enrollment/educational meetings be required for Flex to conduct? ☐ Yes ☐ No

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