



**NEW COMPANY PROFILE**

**Company Information**

Company Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

Type of Entity \_\_\_\_\_ Federal ID# \_\_\_\_\_ Number of Employees \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_ Contact's e-mail \_\_\_\_\_

Contact \_\_\_\_\_ Title \_\_\_\_\_

**Reimbursement Information**

**All claims received in our office will be processed within one week.**

Direct Deposit:  Yes  No      Required for All Employees:  Yes  No

Pay Cycle:  Weekly (52)       Bi-Weekly (26)       Semi-Monthly (24)       Monthly (12)

1<sup>st</sup> two Pay Dates of Plan Year: \_\_\_\_\_

Please list any pay dates on which FSA deductions will not be taken: \_\_\_\_\_

**Plan Information**

Start Date of Plan \_\_\_\_\_ Plan Year Dates \_\_\_\_\_ to \_\_\_\_\_ Run Out Period \_\_\_\_\_ days

Track Premiums  Yes  No      2 ½ Month Grace Period  Yes  No

Prepare Form 5500  Yes  No      Perform Discrimination Test  Yes  No

FBA to prepare Plan Documents  Yes  No      Use Employer's current Plan Documents  Yes  No  
*(If yes, please furnish copy of Plan Document and SPD to FBA)*

Dependent Care Account

Health Care Reimbursement Account      Maximum Election: \$ \_\_\_\_\_

Private Insurance Account

<input type="checkbox"/> Premium Conversion	<input type="checkbox"/> Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Group Term Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Dental Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Plan Number _____	<input type="checkbox"/> Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Vision Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Affiliated Employers? _____	<input type="checkbox"/> Accidental D&D Insurance	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Cancer Insurance	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Employer Contributions?  
\_\_\_\_\_

Automatic enrollment for pre-tax premiums?  Yes  No

If no: Participants who fail to sign a new election form shall:

Continue same elections as prior year

Be considered to have elected not to participate for upcoming Plan year

Health Reimbursement Arrangement (HRA)

Health Savings Account      Health FSA Limited to:  Dental, Vision and Preventive Care

Expenses in excess of HDHP deductible



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**Eligibility**

Exclude the following employees:  Commissioned Employees  Union Employees  
 Leased Employees  Part time employees \_\_\_\_\_  
 Non Resident Aliens  Employees not eligible under group medical plan  
 Other \_\_\_\_\_

Eligibility begins on:  Date of Hire  \_\_\_\_\_ Days after Date of Hire  
 \_\_\_\_\_ Months after Date of Hire  \_\_\_\_\_ Years after Date of Hire

Entry Date:  First day conditions were met  
 First day of following month  
 First day of following pay period  
 First day of following plan year

**Banking Information**

FBA General Reimbursement Account  Company FSA Bank Account  
 Company Signs Checks  FBA Signs Checks *(N/A if Direct Deposit is required)*

Date FSA Checking Account Opened \_\_\_\_\_ Bank Name \_\_\_\_\_ Check Stock Fee \_\_\_\_\_  
 Date Signature Card **and** Voided Starter Check Mailed to FBA \_\_\_\_\_

FBA Benefits Card  Yes  No *(if yes, must have own FSA bank account)*  
 Company paid  Employee paid  
*via per pay period payroll deduction (\$1.50 monthly, 75¢ semi-monthly, 70¢ bi-weekly)*  
 Elective  Mandatory

**Notes**

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**Setup Timeline (For FBA Office Use Only)**

Date Metavante ACH Authorization Release sent \_\_\_\_\_ Date Metavante ACH Authorization Received \_\_\_\_\_  
 Date Contract Sent \_\_\_\_\_ Date Signed Contract Received \_\_\_\_\_  
 Date Enrollment Materials Created \_\_\_\_\_ Date Entered into Client Database \_\_\_\_\_  
 Date Entered into P&W \_\_\_\_\_ Date Affidavits/ASCII file Received \_\_\_\_\_