PAYFLEX®

New Client Checklist (2 to 100)

Welcome to PayFlex. The first step in the set up process is completion of the New Client Checklist Form. We use this form to collect critical information about your plan. Please complete all applicable sections on this form and submit it to **implementation@payflex.com** 60 days prior to your plan start date. Should you require any assistance in completing this form, please contact us at **1-855-462-3056** or send an e-mail to **CBClientSupport@payflex.com**.

Services Requested

Plan Start Date	Plan End Date

Requested Services

Please complete the required sections below for each service type selected.

Note: Any days listed on the New Client Checklist represent calendar days.

- ☐ **Health Reimbursement Account (HRA) –** complete sections 1, 2, 3, 8, 9, 10
- ☐ **Flexible Spending Account (FSA)* -** complete sections 1, 2, 4, 8, 9
- ☐ **Dependent Care Account (DCFSA) –** complete sections 1, 2, 5, 8, 9
- ☐ **Limited Purpose Flexible Spending Account (LPFSA)* –** complete sections 1, 2, 6, 8, 9
- ☐ **Health Savings Account (HSA) –** complete sections 1, 2, 7, 8

* IRS rules don't allow a member to contribute to an HSA if they're covered by a general-purpose FSA. By limiting the FSA reimbursement to dental and vision expenses, the member can participate in both a LPFSA and HSA. To pair an HSA plan with LPFSA, complete **Section 6**.

Section 1 - Customer Information

Employer's Full Legal Name and Address

Federal Tax ID (TIN Number)	Plan Sponsor Number	CSA Number (internal use only)

Corporate Structure

☐ **C-Corp** ☐ **S-Corp*** ☐ **LLC*** ☐ **Partnership*** ☐ **LLP *** ☐ **Non-Profit** ☐ **Other** _____

*Self-employed individuals (i.e. sole proprietor, partner in a partnership, an outside director, members of an LLC) and a more-than-2% shareholder of an S-Corp cannot participate in an FSA, HRA nor Transportation plan, as the IRS definition of employee doesn't include a self-employed individual.

Broker Contact:

Name: _____

Title: _____

Address/City/State/ZIP: _____

_____

Phone: _____

E-mail: _____

Main Employer Contact:

Name: _____

Title: _____

Address/City/State/ZIP: _____

_____

Phone: _____

E-mail *(required)*: _____

Secondary Employer Contact:

Name: _____

Title: _____

Phone: _____

E-mail *(required)*: _____

This signature certifies that I have carefully reviewed the information contained in this document and have verified the accuracy of each benefit plan as described below.

Form Completed by (Print Name)	**Title**
Employer/Broker Signature (required)	**Date**

Section 2 – Enrollment

Estimated Number of Eligible Employees	Estimated Number of Members (*This would include all eligible employees and dependents.*)

An enrollment template and instructions will be provided to you by your Implementation Manager.

Section 3 - Health Reimbursement Account (HRA)

Eligible Expense Types

What eligible expenses will be covered by the HRA plan?

☐ **Medical** (choose one that applies)

☐ **Medical Deductible Only** ☐ **Medical Deductible, Copay, Coinsurance**

☐ **Medical Deductible, Copay, Coinsurance, and all 213(d) Eligible Medical Expenses**
(this includes all medical/pharmacy covered services and both In- and Out-of-Network providers)

☐ **Pharmacy** (This will include all pharmacy deductible, copay, and coinsurance expenses)

Network Services

☐ **In- and Out-of-Network Providers** ☐ **In-Network Providers Only**

Employer HRA Funding Amounts

How much will you allocate for each member's HRA? The funding amount will be determined by the member's coverage status (i.e. employee only, family, etc.). The full HRA funding will be available at the beginning of the plan year.

☐ **Employee / Family**
Employee $_____ **Family $**_____

☐ **3 Tier**
Employee $_____ **Employee + 1 $**_____ **Family $**_____

☐ **4 Tier**
Employee $_____ **Employee + CH $**_____ **Employee + Spouse $**_____ **Family $**_____

Employee Upfront Deductible

You may choose to have members pay an upfront deductible amount prior to using the HRA Fund.

☐ **No** ☐ **Yes**

Employee Upfront Deductible Amounts

If you answered Yes to the upfront deductible, please indicate the upfront amount.

☐ **Employee / Family**
Employee $_____ **Family $**_____

☐ **3 Tier**
Employee $_____ **Employee + 1 $**_____ **Family $**_____

☐ **4 Tier**
Employee $_____ **Employee + CH $**_____ **Employee + Spouse $**_____ **Family $**_____

HRA Rollover

Allow members to rollover remaining HRA dollars at the end of the current plan year's run out period, into the next plan year to be used for expenses incurred in the new plan year.

☐ **No** ☐ **Yes**

☐ **Rollover full amount with no caps or percentage restrictions**

☐ **Rollover Percentage of available balance** _____**%**

☐ **Cap rollover at a specific dollar amount** **$**_____

Percent Reimbursement

Reimburse a certain percentage of HRA eligible expenses, with the remaining amount to be paid by the member. All reimbursements are paid at 100% unless an alternative percent reimbursement is checked below.

☐ **100%** ☐ **50%** ☐ **70%** ☐ **80%** **Other:** _____**%** (must be in 10% increments)

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ **30 Days** ☐ **60 Days** ☐ **90 Days**

Section 4 - Flexible Spending Account (FSA)

Debit Card

*The debit card is **not** an option if you offer a stacked HRA/FSA plan design.*

If No is selected for the debit card, the medical claims will automatically cross over from the medical plan and reimburse the member.

☐ **No** ☐ **Yes**

Debit Card Copay Matching

This information will be used to substantiate debit card transactions.

☐ **No – copayments on the medical plan**

☐ **Yes – copayments on the medical plan** *(must provide detailed plan design listing the copay amounts from the medical Summary Plan Document)*

Maximum Contribution Amount

The maximum salary contribution amount allowed is limited to the IRS amount. .

$_____

Payroll Contribution Frequency

Health care FSA contributions will automatically post to the member's account based on the payroll frequency and first payroll date.

☐ **Weekly (52)** ☐ **Bi-Weekly (26)** ☐ **Semi-Monthly - 1st and 15th (24)**

☐ **Semi-Monthly - 15th and Last Day (24)** ☐ **Monthly - 1st, 15th or Last Day (12)**

First Payroll Contribution Date (*Must be on or after the plan start date.)*

_____/_____/_____

Carryover

Your plan can allow members to carry over up to $500 of unused health care FSA dollars at the end of the plan year.

Note: FSA carryover is not an option if your plan has an FSA grace period.

Note: An FSA balance can carry over to an LPFSA if the member is enrolled in an HSA in the new plan year.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year carryover.

☐ **No** ☐ **Yes**

☐ **$500**

☐ **Other: $**_____

If Yes, is carryover in place for current plan year? ☐ **No** ☐ **Yes**

If Yes, will PayFlex take over current plan year carryover *(additional fee would apply)?* ☐ **No** ☐ **Yes**

Grace Period

An FSA grace period allows members to be reimbursed for eligible medical expenses incurred up to 2 months and 15 days after the plan year ends. If your health care FSA plan has a grace period, the run out period should be no less than 90 days after the end of the plan year.

Note: If your plan has an FSA grace period, you cannot also offer FSA carryover.

Must be in the standard PayFlex file format, if you want PayFlex to take over your current plan year grace period.

☐ **No** ☐ **Yes**

If Yes, is grace period in place for current plan year? ☐ **No** ☐ **Yes**

If Yes, will PayFlex take over current plan year grace period (*additional fee would apply)*? ☐ **No** ☐ **Yes**

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ **30 Days** ☐ **60 Days** ☐ **90 Days**

Do you offer an HRA plan with the FSA plan?

☐ **No – not offering HRA** ☐ **Yes - FSA pays first** ☐ **Yes - HRA pays first**

Section 5 - Dependent Care Account (DCFSA)

Payroll Contribution Frequency

DCFSA contributions will automatically post to the member's account based on the payroll frequency and first payroll date.

☐ **Weekly (52)** ☐ **Bi-Weekly (26)** ☐ **Semi-Monthly - 1st and 15th (24)**

☐ **Semi-Monthly - 15th and Last Day (24)** ☐ **Monthly - 1st, 15th or Last Day (12)**

First Payroll Contribution Date (*Must be on or after the plan start date.)*

_____/_____/_____

Grace Period

An FSA grace period allows members to be reimbursed for eligible dependent care expenses incurred up to 2 months and 15 days after the plan year ends.

If your DCFSA plan has a grace period, the run-out period should be no less than 90 days after the end of the plan year.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year grace period.

☐ **No** ☐ **Yes**

If Yes, is grace period in place for current plan year? ☐ **No** ☐ **Yes**

If Yes, will PayFlex take over current plan year grace period (*additional fee would apply)*? ☐ **No** ☐ **Yes**

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ **30 Days** ☐ **60 Days** ☐ **90 Days**

Section 6 - Limited Purpose Flexible Spending Account (LPFSA)

Debit Card

*The debit card is **not** an option if you offer a stacked HRA/ FSA plan design.*

If No is selected for the debit card, the eligible claims will automatically crossover from the medical plan and reimburse the member.

☐ **No** ☐ **Yes**

Debit Card Copay Matching

This information will be used to substantiate debit card transactions.

☐ **No – copayments on the medical plan**

☐ **Yes – copayments on the medical plan** *(must provide detailed plan design listing the copay amounts from the medical Summary Plan Document)*

Eligible Expense Types

Eligible medical expenses covered by the LPFSA plan.

☐ **Dental and Vision** ☐ **Dental Only** ☐ **Vision Only**

Maximum Contribution Amount

The maximum salary contribution amount allowed is limited to the IRS amount.

$_____

Payroll Contribution Frequency

LPFSA contributions will automatically post to the member's account based on the payroll frequency and first payroll date.

☐ **Weekly (52)** ☐ **Bi-Weekly (26)** ☐ **Semi-Monthly - 1st and 15th (24)**

☐ **Semi-Monthly - 15th and Last Day (24)** ☐ **Monthly - 1st, 15th or Last Day (12)**

First Payroll Contribution Date (*Must be on or after the plan start date.)*

_____/_____/_____

Carryover

Your plan can allow members to carry over up to $500 of unused health care FSA dollars at the end of the plan year.

Note: FSA carryover is not an option if your plan has an FSA grace period.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year carryover.

☐ **No** ☐ **Yes**

☐ **$500**

☐ **Other: $**_____

If Yes, is carryover in place for current plan year? ☐ **No** ☐ **Yes**

If Yes, will PayFlex take over current plan year carryover (*additional fee would apply*)? ☐ **No** ☐ **Yes**

Grace Period

An FSA grace period allows members to be reimbursed for eligible expenses incurred up to 2 months and 15 days after the plan year ends. If your health care FSA plan has a grace period the run out period should be no less than 90 days after the end of the plan year.

Note: If your plan has an FSA grace period you cannot also offer FSA carryover.

Must be in the standard PayFlex file format if you want PayFlex to take over your current plan year grace period.

☐ **No** ☐ **Yes**

If Yes, is grace period in place for current plan year? ☐ **No** ☐ **Yes**

If Yes, will PayFlex take over current plan year grace period (*additional fee would apply*)? ☐ **No** ☐ **Yes**

Run Out Period

The amount of time allowed following the end of the plan year to submit eligible claims for reimbursement.

☐ **30 Days** ☐ **60 Days** ☐ **90 Days**

Do you offer a Limited HRA or HSA plan with the LPFSA plan?

☐ **No – not offering Limited HRA or HSA** ☐ **Yes - LPFSA pays first** ☐ **Yes - HRA pays first**

Section 7 - Health Savings Account (HSA)

HSA

Are you offering an HSA for members enrolled in a Qualified High Deductible Health Plan?

☐ **No** ☐ **Yes**

Employer Contribution

All HSA contributions (employer and employee) reported will be posted via the PayFlex employer portal. The employer will fund the individual HSAs via an ACH transfer from the employer's bank account to the employees' HSA accounts. If this field is left blank we will assume no employer contributions.

☐ **No** ☐ **Yes**

Section 8 - Employer Banking Arrangement/ACH Authorization Release

ACH Authorization Release	BMO/Harris Bank Filter* Information	
Employers: A voided check (if checks are drawn from the account) should accompany this form or the program live date may be delayed. Once completed, please provide to your benefits administrator.	Submitting Bank (ODFI):	Harris Bank F/K/A M&I Bank
☐ **New Customer** ☐ **Current Customer – Update Only**	Company Name (Account Name):	Med-I-Bank
	Routing Number: 075000051Origination ID:	07500005
	Company ID (Daily POS Settlement):	1383261866
	Company ID (Resubmits):	W383261866
	Company ID (HSA Items):	9383261866

This section authorizes PayFlex Systems USA, Inc. ("PayFlex") to initiate debit and credit entries to the bank account you (the "Client") designate below. This authorization is to remain in full effect until written notice of its termination is supplied by you to PayFlex.

☐ Complete ALL required banking information (**Section 8**).
☐ Attach a copy of a voided check from the account. If you don't have checks for this account, ask your bank to provide a MICR encoding specification sheet.
☐ Complete and sign the Check Image (HRA and FSA only) – Signature Request Form (**Section 9**) and return to PayFlex with the New Client Checklist form.
☐ Apply the necessary ACH filters required for debit entry with your bank (See Bank Filter Information above).

IMPORTANT:

- PayFlex will be issuing checks for FSA and HRA claims on behalf of Client. Because of this, you must provide a checking account.
- If you're using an existing bank account that is NOT solely used for a PayFlex product, ensure that the starting check number allows enough of a gap in the check number range to avoid producing duplicate checks.
- Any banking changes will require the completion of a new banking form and a voided check/MICR specification sheet. Please allow up to 72 business hours from the date of notification to complete the banking change.
- The bank account will be subject to a $1.00 pre-notification to confirm that the account is valid and live. The debit will appear as Med-I-Bank on your bank statement.

Bank/Depository Name and Address		
Bank Routing Number	Bank Account Number	Starting Check Number *(does not apply to HSA)* *If starting check number is not provided we'll start with check number 1001*

Authorization to Disburse

Client hereby authorizes PayFlex Systems USA, Inc. as a limited agent for the purpose of withdrawing funds from the account indicated above at the named financial institution for the payment of claims under a benefit plan established by Client for the benefit of its employees. Client agrees that the account shall be fully funded by Client to assure that all necessary funding, as applicable, is available to pay claims and any applicable fees. Client understands and agrees that PayFlex Systems USA, Inc. shall have no obligations to pay claims Client does not sufficiently fund with the account.

☐ Client hereby authorizes PayFlex Systems USA, Inc. to initiate ACH (automated clearing house) transfer entries for the depository indicated above for claims reimbursement and any applicable fees at the depository named above, hereinafter called Depository. Client acknowledges that the origination of these transactions to/from its account must comply with the provisions of applicable law.

☐ (Applies only if using a debit card) Client hereby authorizes PayFlex Systems USA, Inc. to initiate ACH (automated clearing house) transfer entries for the depository indicated above for daily debit card transactions. Bounced automated withdrawals from Client's account will incur a $25 charge and will require immediate action to prevent cards from being turned off.

☐ I have read the Policy for ACH Failures and have discussed concerns with my Implementation Manager. I understand and will ensure that the process has been adopted by my organization.

Print Name of Authorized Representative (required)	**Title**
Signature of Client's Authorized Representative (required)	**Date**

Section 9 – Electronic Check Signature

Check Image – Signature Request Form

Please complete the following, so that we have a signature to place on printed checks:

Check Signer – Basic Information

Full Name (Please Print): _____

Company: _____

Title: _____

Check Signature

Please provide a signature in the box below. This is the signature that will be placed on checks printed on behalf of your organization. **Please keep the signature within the black box below – sign with black ink.**

Sign Here:

Section 10 – Representations required for all Health Reimbursement Accounts (HRA)

This form is a representation from the employer that the HRA PayFlex is administering with plan years beginning on or after January 1, 2014 on behalf of the employer complies with the Affordable Care Act (ACA) prohibition provisions. Administration of the accounts is provided pursuant to the separate services agreement in effect. By signing this form and checking the appropriate box, the employer represents that its HRA is/are:

☐ Integrated HRA ☐ Retiree-only HRA ☐ HIPAA-excepted HRA

☐ Small Benefit HRA

In addition, by signing this form, the employer further represents:

- The employer will promptly notify PayFlex of any changes with respect to the HRA eligibility terms or the employer's group health coverage that impact the above requirements;
- The employer is aware that it may be subject to fees, penalties and other costs if coverage is provided to members under an HRA without satisfying the applicable requirements; and
- The employer is aware that it is the employer's obligation to either satisfy any new requirements regarding the definition of an integrated HRA or to promptly notify PayFlex that such new requirements are not satisfied.
- The employer in consultation with its legal counsel has determined that the HRA design selected above complies with ACA requirements.

The employer acknowledges that PayFlex is relying upon these representations in administering HRAs for employer.

Employer Name	
HRA Plan Name	
Primary Contact Name	
Authorized Plan Sponsor Signature	**Date**

Aetna Consumer Financial Solutions products are administered by PayFlex Systems USA, Inc., an affiliate of Aetna Life Insurance Company.