# CLIENT INFORMATION

| | |
|---|---|
| Company Legal Name: | |
| DBA Name | |
| *Other Names, If applicable* | |
| Mailing Address | |
| Company Main Phone # | |
| Tax ID | |
| Organization Type | ☐ C-Corp ☐ LLC * ☐ Sole Proprietorship<br>☐ S-Corp* ☐ Church ☐ Other-Tax Exempt<br>☐ Non-Profit ☐ Government Entity |
| | **S-Corp and LLC 2% or more owners and their family members are not eligible for certain tax-advantaged plans due to IRS rules. Employers are responsible for ensuring owner eligibility in all plans including section 125, FSA, HSA, HRA, etc.* |
| State Incorporated | |
| Divisions | ☐ No ☐ Yes, List divisions:<br>If yes, is separate reporting needed for divisions? ☐ No ☐ Yes |
| Reporting Preferences | ☐ Include Employee Names ☐ Do not Include Employee Names |
| | ☐ Email with Reports attached (Employee names **not** included) ☐ Email to access Report in employer portal (Employee names **can** be included) |
| Payroll Provider | Provider Name: |
| | Feed Integration: ☐ Enrollments ☐ COBRA ☐ **HSA** Contributions |
| Benefit Administration Platform | Provider Name: |
| | Feed Integration: ☐ Enrollments ☐ COBRA |
| Number of Employees | Total: Benefit Eligible: |
| Are you subject to FMLA? | ☐ No ☐ Yes |

## Contact Information

| | | |
|---|---|---|
| Primary: | Title | Email |
| Phone #: | ☐ Health Accounts ☐ COBRA | Portal Access ☐ Yes ☐ No |
| Secondary: | Title | Email |
| Phone #: | ☐ Health Accounts ☐ COBRA | Portal Access ☐ Yes ☐ No |
| Additional: | Title | Email |
| Phone #: | ☐ Health Accounts ☐ COBRA | Portal Access ☐ Yes ☐ No |
| Additional: | Title | Email |
| Phone #: | ☐ Health Accounts ☐ COBRA | Portal Access ☐ Yes ☐ No |
| Additional: | Title | Email |
| Phone #: | ☐ Health Accounts ☐ COBRA | Portal Access ☐ Yes ☐ No |
| **Billing Contact*:** Who should receive invoices? | | |
| **Enrollment Contact*:** Who should we contact re. enrollment discrepancies? | | |
| **Reporting Contact*:** Who should receive funding reports? | | |
| **Signatory Contact*:** Who should agreements be sent to? | | |

## Broker/Account Executive

| | |
|---|---|
| Brokerage Name and Location: | |
| Broker: Access to Portal? | ☐ No ☐ Yes, who: |
| **Broker Contact Details – Name, Email, Phone:** | |
| Broker | |
| Account Manager: | |
| Service Rep.: | |

# Employer ACH Bank Account Setup

| | |
|---|---|
| Use For: *Select All Those Applicable*<br>☐ Reimbursements<br>☐ Debit Card Funding<br>☐ Billing<br>☐ HSA Funding<br>☐ COBRA *(Do not check if you want check reimbursement)* | Account Type: ☐ Checking ☐ Savings<br>Routing Number:<br>Account Number: |
| Bank Name: | |
| Bank Address: | |
| Additional Account | If a second bank account should be used for specific purposes or for a specific division (ex. COBRA or Billing): |
| | Use: Account Type: ☐ Checking ☐ Savings<br>Routing Number: Account Number: |
| Does this bank account utilize positive pay to prevent deposits/withdrawals? | ☐ No ☐ Yes *If you responded yes: CHS can provide our bank information to be added as an authorized account to deposit and withdraw funds. |

## COBRA Premium Reimbursement by Mail

| **For Premium Reimbursement through check, please complete the following information. Do not complete this if you want COBRA premiums remitted by ACH.** | |
|---|---|
| Pay to the Order of: | |
| Attention to: | |
| Mailing Address: | |

## Fees (As Established in Proposal)

| | |
|---|---|
| Health Account Administration | Setup/Renewal Fee: **As established in proposal**<br>Per Active Participant Per Month: **As established in proposal** |
| Debit Card | Initial Set of Debit Cards: $0<br>Additional set of replacement cards: $5<br>(charged to the participant unless otherwise indicated by employer) |
| Other fees where applicable: | Discrimination Testing Fee: $150<br>Mid-year termination fee: $300 plus one month's administration fee (termination prior to 30 days before the end of the plan's year)<br>Mid-year plan change fee: Minimum of $300<br>Outside administrator plan takeover: $300<br>Pay the Provider HRA fee: $15 / month<br>Employee Navigator Fee: $15 / month |
| COBRA | Ongoing Administration: 2% of premium billed per COBRA elected participant. (Collected from the participant)<br>COBRA Monthly Administration Fee: Based on number of benefit eligible employees at the time of setup and recalculated annually at renewal.<br>**As established in proposal.** |

# Plan Authorization

***Instructions***: Please complete this plan authorization page after all plan information has been entered in the below pages. This authorization certifies that all plan information provided is correct. This form is required to be signed before Consumer Health Solutions will initialize/go live with the plans.

Please contact Health Accounts or COBRA at Consumer Health Solutions with any plan questions prior to signing the authorization.

*I hereby certify that the information provided in the Health Accounts and COBRA plan setup is accurate.*

*I understand that:*

- *Consumer Health Solutions will build and initialize the plans based on the information provided in these documents.*
- *Changes to the plans after the setup will result in* ***a minimum fee of $300.***
- *Consumer Health Solutions will initialize the plans once the authorization page is provided.*

| | |
|---|---|
| Company Name: | |
| Authorizer Name: | |
| Signature: | |
| Date: | |

# COBRA Information

| | | |
|---|---|---|
| Company Legal Name: | | |
| Which plans are eligible for COBRA: | ☐ Medical # of Plans:<br>☐ Dental # of Plans:<br>☐ Vision # of Plans:<br>☐ Rx Standalone:<br>☐ FSA<br>☐ HRA<br>☐ EAP<br>☐ Other: | |
| Live date for COBRA administration with CHS: | | |
| Current COBRA Administration: | ☐ Self-administered<br>☐ Cobra Vendor - Name of Current Administrator: | |
| Are there specific divisions for COBRA? | ☐ No<br>☐ Yes, please list: | |
| # of Participants Enrolled in COBRA: | | *If you have any participants enrolled in cobra or pending participants, please complete the COBRA takeover census.* |
| # of Pending COBRA Participants: | | |
| # of Employees enrolled in a COBRA Eligible Plans: | | |
| Do you need Open Enrollment notices sent to existing QBs? | ☐ No* *default*<br>☐ Yes, dates of open enrollment: | |
| Are there any ongoing carrier issues to be aware of?<br>*Ex. Outdated termination appeal* | ☐ No<br>☐ Yes, please explain: | |
| Are you subject to State Continuation? | ☐ No<br>☐ Yes, please list the state(s): | |
| Do you want to be notified of every carrier coverage change per person per plan? | **Please note:** This notification is **<u>one email per line of coverage per subscriber</u>**<br>Please consider your size prior to making a choice. You will be notified of each month's remittance.<br>☐ No (Default)<br>☐ Yes | |

# Medical Plan Information

| Medical Plan 1 | | |
|---|---|---|
| Carrier Name: | | |
| Plan Name: | | |
| Plan Type: | | |
| Plan Policy ID: | | |
| Available for what divisions: | ☐ All<br>☐ Specify which divisions: | |
| Insured: | ☐ Fully Insured<br>☐ Self-Insured | |
| Carrier Account Management Contact: | Name:<br>Email Address:<br>Phone Number: | |
| Has carrier been notified of CHS as the COBRA vendor? | ☐ Yes | |
| Plan Year Dates: | | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month | |
| Is this plan bundled with another plan? | ☐ Yes, Indicate what plan:<br>☐ No | |
| Conversion to Individual Plan allowed? | ☐ Yes<br>☐ No | |
| Is this a new plan or renewing plan? | ☐ Renewing Plan<br>☐ New Plan - This plan replaces: | |
| For age banded rates, when do premiums change? | ☐ Enrollment Date<br>☐ Birthday<br>☐ Plan Renewal Date | |
| Premium Rates | Enter Monthly COBRA Premiums: (do not include the 2% admin fee) | |
| | **Premium Level** | **Composite Premium Amount** |
| | Employee Only | $ |
| | Employee + Spouse | $ |
| | Employee + Child | $ |
| | Employee + Children<br>*(**Only If different** from EE + Child)* | $ |
| | Employee + Family | $ |
| **If Rates are age banded or otherwise non-composite, please attach the rate information separately.** | | |

# Dental Plan Information:

| Dental Plan 1 | | |
|---|---|---|
| Carrier Name: | | |
| Plan Name: | | |
| Plan Type: | | |
| Plan Policy ID: | | |
| Available for what divisions: | ☐ All<br>☐ Specify which divisions: | |
| Insured: | ☐ Fully Insured<br>☐ Self-Insured | |
| Carrier Account Management Contact: | Name:<br>Email Address:<br>Phone Number: | |
| Has carrier been notified of CHS as the COBRA vendor? | ☐ Yes | |
| Plan Year Dates: | | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month | |
| Is this plan bundled with another plan? | ☐ Yes, Indicate what plan:<br>☐ No | |
| Conversion to Individual Plan allowed? | ☐ Yes<br>☐ No | |
| Is this a new plan or renewing plan? | ☐ Renewing Plan<br>☐ New Plan - This plan replaces: | |
| For age banded rates, when do premiums change? | ☐ Enrollment Date<br>☐ Birthday<br>☐ Plan Renewal Date | |
| Premium Rates | Enter Monthly COBRA Premiums: (do not include the 2% admin fee) | |
| | **Premium Level** | **Composite Premium Amount** |
| | Employee Only | $ |
| | Employee + Spouse | $ |
| | Employee + Child | $ |
| | Employee + Children<br>*(**Only If different** from EE + Child)* | $ |
| | Employee + Family | $ |
| **If Rates are age banded or otherwise non-composite, please attach the rate information separately.** | | |

# Vision Plan Information:

| Vision Plan 1 | | |
|---|---|---|
| Carrier Name: | | |
| Plan Name: | | |
| Plan Type: | | |
| Plan Policy ID: | | |
| Available for what divisions: | ☐ All<br>☐ Specify which divisions: | |
| Insured: | ☐ Fully Insured<br>☐ Self-Insured | |
| Carrier Account Management Contact: | Name:<br>Email Address:<br>Phone Number: | |
| Has carrier been notified of CHS as the COBRA vendor? | ☐ Yes | |
| Plan Year Dates: | | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month | |
| Is this plan bundled with another plan? | ☐ Yes, Indicate what plan:<br>☐ No | |
| Conversion to Individual Plan allowed? | ☐ Yes<br>☐ No | |
| Is this a new plan or renewing plan? | ☐ Renewing Plan<br>☐ New Plan - This plan replaces: | |
| For age banded rates, when do premiums change? | ☐ Enrollment Date<br>☐ Birthday<br>☐ Plan Renewal Date | |
| Premium Rates | Enter Monthly COBRA Premiums: (do not include the 2% admin fee) | |
| | **Premium Level** | **Composite Premium Amount** |
| | Employee Only | $ |
| | Employee + Spouse | $ |
| | Employee + Child | $ |
| | Employee + Children<br>*(**Only If different** from EE + Child)* | $ |
| | Employee + Family | $ |
| **If Rates are age banded or otherwise non-composite, please attach the rate information separately.** | | |

# HRA (If Applicable)

| | |
|---|---|
| Administrator Name: | |
| Administrator Contact Information<br>*Note: Self-administered HRA's are subject to COBRA* | Name:<br>Email Address:<br>Phone Number: |
| Applies To: | ☐ All available medical plans<br>☐ Specific medical plans:<br>☐ HRA is tied to a non-medical plan: |
| Are Cobra participants allowed to elect the medical insurance plan WITHOUT the HRA? | ☐ Yes<br>☐ No - Participation in this medical plan automatically includes participation in the HRA |
| Plan Year Dates | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month |
| HRA Rates:<br>**HRA rates must be provided by the employer. Calculation assistance is outlined below.* | Employee Only: |
| | Employee + Spouse: |
| | Employee + Child: |
| | Employee + Children:<br>*(**Only If different** from EE + Child)* |
| | Employee + Family: |

**Past Cost HRA Premium Calculation Method**

**Eligibility Note**

The HRA must have been in force for a minimum of 12 months without material plan design changes that could significantly impact utilization.

**Required Information**

- Prior plan year utilization rate (Current plan year, if effective date is in the future)
  *(Total reimbursements paid ÷ total HRA exposure)*
- Current plan year reimbursement maximums by coverage tier (New plan year, if the effective date is in the future) *(e.g., single, employee + spouse, family)*

**Calculation Method**

For each coverage tier, the estimated monthly HRA premium is calculated as:

*(Utilization Rate × Reimbursement Maximum for the Coverage Tier) ÷ 12*

***For further information on HRA premium calculation please refer to § 4980B(f)(4)(A) of the IRS Code.***

# FSA (If Applicable)

| | |
|---|---|
| Administrator Name: | |
| Carrier Contact Information | Name:<br>Email Address:<br>Phone Number: |
| Plan Name: | |
| Plan Year Dates | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month |
| FSA Renewal Month: | |

# Other Plan Offerings

| Additional Plan | | |
|---|---|---|
| Carrier Name: | | |
| Plan Name: | | |
| Plan Type: | | |
| Plan Policy ID: | | |
| Available for what divisions: | ☐ All<br>☐ Specify which divisions: | |
| Insured: | ☐ Fully Insured<br>☐ Self-Insured | |
| Carrier Account Management Contact: | Name:<br>Email Address:<br>Phone Number: | |
| Has carrier been notified of CHS as the COBRA vendor? | ☐ Yes | |
| Plan Year Dates: | | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month | |
| Is this plan bundled with another plan? | ☐ Yes, Indicate what plan:<br>☐ No | |
| Conversion to Individual Plan allowed? | ☐ Yes<br>☐ No | |
| Is this a new plan or renewing plan? | ☐ Renewing Plan<br>☐ New Plan - This plan replaces: | |
| For age banded rates, when do premiums change? | ☐ Enrollment Date<br>☐ Birthday<br>☐ Plan Renewal Date | |
| Premium Rates | Enter Monthly COBRA Premiums: (do not include the 2% admin fee) | |
| | **Premium Level** | **Composite Premium Amount** |
| | Employee Only | $ |
| | Employee + Spouse | $ |
| | Employee + Child | $ |
| | Employee + Children<br>*(**Only If different** from EE + Child)* | $ |
| | Employee + Family | $ |
| **If Rates are age banded or otherwise non-composite, please attach the rate information separately.** | | |

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| Additional Plan | | |
|---|---|---|
| Carrier Name: | | |
| Plan Name: | | |
| Plan Type: | | |
| Plan Policy ID: | | |
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| Insured: | ☐ Fully Insured<br>☐ Self-Insured | |
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| Has carrier been notified of CHS as the COBRA vendor? | ☐ Yes | |
| Plan Year Dates: | | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month | |
| Is this plan bundled with another plan? | ☐ Yes, Indicate what plan:<br>☐ No | |
| Conversion to Individual Plan allowed? | ☐ Yes<br>☐ No | |
| Is this a new plan or renewing plan? | ☐ Renewing Plan<br>☐ New Plan - This plan replaces: | |
| For age banded rates, when do premiums change? | ☐ Enrollment Date<br>☐ Birthday<br>☐ Plan Renewal Date | |
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| | **Premium Level** | **Composite Premium Amount** |
| | Employee Only | $ |
| | Employee + Spouse | $ |
| | Employee + Child | $ |
| | Employee + Children<br>*(**Only If different** from EE + Child)* | $ |
| | Employee + Family | $ |
| **If Rates are age banded or otherwise non-composite, please attach the rate information separately.** | | |

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| Additional Plan | | |
|---|---|---|
| Carrier Name: | | |
| Plan Name: | | |
| Plan Type: | | |
| Plan Policy ID: | | |
| Available for what divisions: | ☐ All<br>☐ Specify which divisions: | |
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| Has carrier been notified of CHS as the COBRA vendor? | ☐ Yes | |
| Plan Year Dates: | | |
| Coverage End Date: | ☐ Event Date<br>☐ End of Month | |
| Is this plan bundled with another plan? | ☐ Yes, Indicate what plan:<br>☐ No | |
| Conversion to Individual Plan allowed? | ☐ Yes<br>☐ No | |
| Is this a new plan or renewing plan? | ☐ Renewing Plan<br>☐ New Plan - This plan replaces: | |
| For age banded rates, when do premiums change? | ☐ Enrollment Date<br>☐ Birthday<br>☐ Plan Renewal Date | |
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| | Employee + Child | $ |
| | Employee + Children<br>*(**Only If different** from EE + Child)* | $ |
| | Employee + Family | $ |
| **If Rates are age banded or otherwise non-composite, please attach the rate information separately.** | | |