

FLEXIBLE SPENDING ARRANGEMENT (FSA) PLAN RENEWAL CHECK LIST

EMPLOYER INFORMATION

Employer Legal Name	Federal Employer ID No. / Tax ID No.		
Primary Contact Name /Title	Fax	Email	
Secondary Contact Name /Title	Phone	Fax	Email
Broker Information	Phone	Fax	Email

ARE THERE ANY CHANGES BEING MADE TO THE FSA PLAN FOR THE UPCOMING PLAN YEAR? Yes No

If yes, please answer the questions listed below that pertains to the changes being made and notify our office if you'd like to make any amendments to your current Plan Document/SPD (additional fee applies).

If no, please return this page along with signature page to Asure Software.

****NOTE:** If the questions listed on this not answered, we will use the prior year's renewal documents.

ADMINISTRATION DATA

Plan Year Start and End Dates: **From:** _____ **To:** _____

Open Enrollment Start and End Dates: **From:** _____ **To:** _____

Total Number of Employees: _____ Total Number of Eligible Employees: _____

WOULD YOU LIKE TO OFFER THE BENEFITS DEBIT CARD? Yes No

This card can be utilized for FSA eligible expenses at authorized merchants (no additional charge applies for employee card).

PLAN DESIGN

What are the minimum/maximum annual contribution amounts that your plan permits on the following services?

	ANNUAL MINIMUM ELECTION	ANNUAL MAXIMUM ELECTION	IRS MAXIMUM
HEALTHCARE FSA			\$2,700 ANNUAL MAXIMUM
DEPENDENT CARE FSA			\$5,000 (single/married filing jointly) \$2,500 (married filing separately)
LIMITED FSA			\$2,700 ANNUAL MAXIMUM

WOULD YOU LIKE TO OFFER A RUN-OUT PERIOD? Yes No **Months:** _____ **Actual Date:** _____

(Not required by IRS. IRS Run-Out Period Maximum is 90 days)

The Run-Out Period permitted under IRS Notice 2005-42 extends the time for submitting expenses that were incurred during the coverage period (FSA plan year). The run-out period may be offered with or without a grace period. If offered with a grace period, the run-out period would begin after the grace period.

WOULD YOU LIKE TO OFFER A GRACE PERIOD? Yes No Months: _____ Actual Date: _____
 (Not required by IRS. IRS grace period maximum is 2 ½ months)

The grace period permitted under IRS Notice 2005-42 extends the time during which expenses may be incurred. It is different from a claim run-out period and may be offered with or without a run-out period. The grace period only applies to employees who were active with the FSA on the last day of the plan year. The grace period does not apply to employees that terminate employment before the end of the plan year.

WOULD YOU LIKE TO OFFER A CARRYOVER OPTION?
 Yes No Maximum Carryover (\$500 max): _____ Minimum Carryover: _____

The Carryover option permitted under IRS Notice 2013-71 allows Health FSAs participants the option of carrying over up to \$500 at the end of the plan year, to be used for qualified medical expenses incurred in a subsequent plan year. The maximum amount allowed must be the same across all participants. **This option can be offered with a Run-Out Period but cannot be offered with a Grace Period.**

DO YOU WANT TO ALLOW MID-YEAR ELECTIONS CHANGES FOR A QUALIFYING CHANGE IN STATUS? Yes No

A change in status must be reported to the plan administrator within 30 days. The FSA election change will be effective the first of the month following receipt of the Qualifying Election Change form. The employer should begin withholding the new FSA election amount the first pay period of the month following the effective date of the change.

When does the FSA participation cease for a Terminated Employee?

Date of termination The last day of the month following date of termination

What is the claim submission period for Terminated Employees to submit claims that were incurred prior to their Termination Date? 90 days Other: _____

Would like to implement the “Spend-Down” provision for the Dependent Care Participants? Yes No

This allows a terminated Dependent Care participant to continue using their available funds after they've ceased to be a participant, through the end of the plan year.

PAYROLL/CONTRIBUTION FREQUENCY (PLEASE INDICATE IF MORE THAN ONE): Semi-Monthly Bi-Weekly Weekly Monthly

DOES YOUR COMPANY HAVE DEPARTMENTS, LOCATIONS, SUBSIDIARIES, OR BRANCHES THAT YOU WOULD LIKE US TO SETUP IN OUR SYSTEM FOR REPORTING PURPOSES?

Yes (if yes, please specify the department, location and/or branch names and if you have specific codes you would like us to utilize)

Departments Locations Subsidiaries Branches

No

DO ALL OF YOUR DEPARTMENTS, LOCATIONS, OR BRANCHES USE THE SAME BANK ACCOUNT? Yes No

CLAIMS

MANUAL CLAIMS REIMBURSEMENT FREQUENCY: Daily (as claims are processed) Weekly (Mondays)

WHICH REIMBURSEMENT OPTIONS WOULD YOU LIKE TO OFFER TO YOUR EMPLOYEES: Check Direct Deposit

WHO WITHIN YOUR ORGANIZATION WOULD YOU LIKE TO RECEIVE OUR FUNDING REPORTS FOR MANUAL CLAIM REIMBURSEMENTS AND DEBIT CARD SETTLEMENT FUNDING?

Name: _____ Email: _____
 Name: _____ Email: _____
 Name: _____ Email: _____

BANK INFORMATION

For debit card funding and manual claim processing, please provide banking information for a business checking account. This is referred to as the Employer Funding Account. Manual claim reimbursements via check and/or direct deposit will be cut from this bank account based on your reimbursement frequency and card transactions will be deducted via ACH daily. Asure Software will issue a summary of card settlement daily, and the funds will deducted the following day. Clients will also receive detail reporting of manual claim payment and card transaction details weekly (or other frequency if desired).

During Implementation, a \$1 non refundable ACH debit pre-note will be initiated to verify the account. If you have an ACH block on the bank account, the following ACH filter information should be communicated to your bank to ensure the ACH debits are not blocked.

Submitting Bank: M&I Bank
 Routing Number: 075000051
 Company ID: 1383261866

Company Name (Account Name): Metavante
 Origination ID: 07500005
 Tax ID: 38-3261866

EMPLOYER'S BANKING INFORMATION

Name of Bank: _____ Name on Account: _____
 Bank Routing Number: _____ Account Number: _____

Authorized signature(s) to use for electronic signature on manual claim checks:
 (Please sign inside the box with BLACK)

Starting Check Number to use for check reimbursements: _____
 (Starting check # 500 will be used if a number is not specified)

I HAVE REVIEWED THE INFORMATION PROVIDED HEREIN AND HAVE VERIFIED THAT IT IS ACCURATE AND COMPLETE. As information changes, it is the responsibility of the employer to communicate the changes in a timely manner to Asure Software.

Company Name: _____

Signature _____ Date _____

PRINT NAME _____ Title _____