Northeast Benefits Management, LLC
Application for Administration

Employer Information

Legal Company Name (including punctuation)	Tax ID	
Mailing Address	City	
Address 2	State	ZIP
Physical Address (if different)	City	
Address 2	State	ZIP

Phone (area code) – Main company line – not a toll-free number	Fax (area code)

Employer/Corp Entity: (check one) ☐C Corporation ☐S Corporation ☐Partnership
☐Limited Liability taxed as: (circle one) Partnership/Corporation/S Corp
☐Government or Church ☐Non-profit ☐Other ________________

An Employer may provide tax-free benefits only to employees, former employees, retirees, and their spouses or covered tax dependents. Because self-employed individuals are not "employees," an Employer may not provide tax-free benefits to self-employed individuals (i.e., sole proprietors, partners, and 2% or more Subchapter S corporation shareholders & applicable family members).

Name(s) of Owner(s) if applicable: ____

Will owners be participating in the HRA? Yes/No If yes, names? ______________________

Total Number of Employees: ____________ Number of Benefit-Eligible Employees:____________
(numbers should include affiliated employers, if any)

Will your plan include any affiliated employers?
☐ No ☐ Yes (if yes, please include affiliated employer information on page 3)

Eligibility (must match eligibility for medical plan)

Hours per week (for example, working 30 or more hours): ______________

Entry Date (for example, eligible first of the month coincident with **or** next following 30 days of employment): ______________________

Rehires (if eligibility is different from new hires):____

Plan Contact (questions regarding plan)	Email	Phone
Funding Contact (funding requests)	Email	Phone
Billing Contact (invoices and payments)	Email	Phone
HIPAA Contact	Email	Phone

Employee Benefits Simplified

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COBRA Administrator name & address:		Phone

Current Benefits

Please check below the benefits your company **currently** offers employees:

- ☐ HRA **(Please provide a copy of your SPD)**
- ☐ Section 125 Plan **(Please provide a copy of your SPD) ***
- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ EAP
- ☐ Parking/Transit Account
- ☐ Health FSA
- ☐ Dependent Care FSA
- ☐ HSA (Health Savings Account)

* If employee insurance premiums and/or HSA contributions are deducted from their paychecks on a pre-tax basis, a Section 125 plan must be in place. Please contact us at (802) 865-0239 or info@nbmus.com if you wish to discuss setting this option up for your employees.

HRA Plan Design Options (Note: providers are reimbursed directly for medical expenses)

What is your underlying medical plan: ______________________________

Please be very specific about your HRA reimbursement formula (percentages, etc): ______________________________

☐ Reimburse underlying medical plan and Rx expenses applied to the deductible ONLY
☐ Reimburse ALL eligible expenses such as deductibles, copays and coinsurance for underlying medical plan (including Rx)

Required: Maximum HRA benefit for Single Coverage: $__________ 2 Person $__________ Family Plan $____________
☐ Include a Debit Card? (Debit cards are not available for all HRA formulas. Please contact us to discuss)

If you offer Flexible Spending Accounts, would you like to include claims administration for your Health and/or Dependent Care FSAs?
☐ Yes (FSA claims administration may be added to the plan for an additional fee.) ☐ No
A General and Limited Health FSA may be available with HSA-compatible plans.

If you offer HSA's (Health Savings Accounts) will you be using NBM's HSA? ☐ Yes ☐ No
Will you be transferring HSA accounts and assets from another entity? ☐ Yes ☐ No

If yes, what is the name of your current HSA administrator? ______________________________

Do you want NBM to prepare signature-ready PCORI, Form 720 documents? ☐ Yes (additional charges may apply) ☐ No
Do you want NBM to perform the HRA nondiscrimination testing? ☐ Yes (additional charges may apply) ☐ No *
If your plan is required to file Section 111 reporting, do you want NBM to file this reporting? ☐ Yes (additional charges apply) ☐ No
* Checking "No" will result in a Hold Harmless letter as testing is required under Code Section 105(h)

Run-Out: ☐ 90 Days following the end of the plan year (standard option) ☐ Other:
Run-Out is the date after the end of the plan year the HRA will continue to reimburse for expenses incurred during the previous plan year.

Run-Out for Terminated Employees (if different from above)
Note: The HRA will reimburse terminated employees for expenses that were incurred on or before their termination from the plan, if received within this time frame.
☐ Same as above (standard option) ☐ Other:

Employee Benefits Simplified

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Will the HRA benefits be pro-rated for employees enrolling mid-year? ☐ No (participants will receive the full benefit regardless of enrollment date) ☐ Yes (if yes, benefits will be pro-rated by number of months enrolled)
Do you have a previous HRA with a roll-over funds provision? ________ If yes, please forward the prior carriers roll-over report once your run-out has ended. (Additional fees apply)

Banking Information

Please provide the bank account information for advance and ongoing funding for your HRA and/or HSA accounts

Bank Name	Bank Address
Bank Phone	Account Type
Routing Number	Account Number
Person Authorizing	Phone Number

Please confirm with your financial institution that there are no debit blocks on your account prior to the effective date of your NBM account.

As an authorized representative of ____(the "Company"), I authorize Northeast Benefits Management, LLC ("NBM") to withdraw at such time as it deems necessary the amount owing for the provision of our Health Reimbursement Arrangement, HSA accounts, Medical and Dependent Care FSA and other associated fees. It is the responsibility of the Company to verify whether these payments are properly debited to its bank account, and the Company will notify NBM of any change in banking information for purposes of ensuring the proper application of payments.

Signature	Date

Affiliated Employer(s)

Legal Company Name (including punctuation)	Tax ID	
Mailing Address	City	
Address 2	State	ZIP
Physical Address (if different)	City	
Phone (area code)	Fax (area code)	

Employer Entity taxed as: (check one) ☐C Corporation ☐S Corporation ☐Partnership

Name(s) of Owner(s) if applicable:____

Will owners be participating in the HRA? **Yes/No** If yes, names? ____

Employee Benefits Simplified

Rev 11/2020

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Authorization

As we are a separate entity from your medical carrier, it is important to keep us updated on new or terminated participants, a change in a participant's status or their mailing address. This can be done through the employer portal on our website (www.nbmus.com) or via paper forms. A User Guide will be provided to the Plan contact you have designated on this application.

I hereby authorize Northeast Benefits Management, LLC to provide reimbursement account services based on the information provided on this form. I understand that any changes made to our plan design after the initial implementation, may result in additional fees.

Signature	Date

Thank You for your Business!

Employee Benefits Simplified