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 4)

Eligibility (must match eligibility for medical plan indicated on Group Enrollment Agreement)

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
Broker	Email	Phone
COBRA Administrator name & address:	Email	Phone

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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)**

Plan Effective Date:	

For A-D below, please select the type of reimbursement and complete the below **Required*** maximum benefit amounts:

☐ Reimburse eligible expenses applied to the medical & Rx deductible ONLY
☐ Reimburse all eligible medical & Rx expenses such as deductible, copays or coinsurance

***Required**: Maximum HRA benefit for Single Coverage: $__________ 2 Person $__________ Family Plan $____________

A. ☐ 50/50 HRA from First Dollar (HRA pays at 50% of each claim, 50% or 100% Rx if Debit Card chosen)
☐ Include an Rx Debit Card (pays 50% or 100%, please indicate which percentage for debit card) __________

B. ☐ 50/50 HRA after $1,400/$2,800 (HSA compatible)

C. ☐ 100% HRA after $1,400/$2,800 (HSA compatible)

D. ☐ 100% HRA from First Dollar ☐ Include an Rx Debit Card (pays 100%)

E. ☐ Custom HRA Design (please outline your preferred plan design in the comment section)

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 the HSA-compatible plans.

If you offer HSA's (Health Savings Accounts) will you be using NBM's HSA? ☐ Yes ☐ No
If yes, please contact us for an HSA administration proposal.
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 *
Do you want NBM to perform the Medical nondiscrimination testing? ☐ Yes (additional charges 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:

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Will the HRA benefits be pro-rated for employees enrolling mid-year?	Will the HRA plan provide coverage for Domestic Partners?
☐ No (participants will receive the full benefit regardless of enrollment date) ☐ Yes (if yes, benefits will be pro-rated by number of months enrolled)	☐ Yes ☐ No
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)	If domestic partners are enrolled in your HRA, it is the Employer's responsibility to ensure that the employee is taxed for this benefit, similarly to how you are taxing their health insurance premiums. For purposes of calculating imputed income for domestic partners and their HRA, employers commonly use HRA COBRA rates attributable to the coverage level added for the non-tax dependent domestic partner as a measure of fair market value for the coverage provided.

Employer HRA Funding

HRA funding will be transferred from the bank account you provide in the next section. You will be notified electronically of weekly funding required to process claims. Additional processing dates may be added if you offer debit cards.

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, 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

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Affiliated Employer(s)

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)	Fax (area code)	

Employer Entity taxed as: (check one) ☐C Corporation ☐S Corporation ☐Partnership
☐Limited Liability taxed as: (circle one) Partnership/Corporation/S Corp
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Name(s) of Owner(s) if applicable:____
Will owners be participating in the HRA? **Yes/No** If yes, names? ___________________________________

Please attach additional pages if needed to include additional employers.

NOTES: **Please be very specific about your HRA reimbursement formula for any custom plan designs.**

Authorization

As we are a separate entity from your medical carrier, it is important to also 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!

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