

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) <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability taxed as: (circle one) Partnership/Corporation/S Corp <input type="checkbox"/> Government or Church <input type="checkbox"/> Non-profit <input type="checkbox"/> Other _____		
Seek advice of your Accountant and also notify us of any changes to entity type or ownership that occurs (or is anticipated) during the plan year.		
An Employer may provide tax-free benefits to employees, former employees, retirees, and their spouses or covered tax dependents. Because self-employed individuals are <u>not</u> "employees," an Employer may <u>not</u> provide tax-free benefits to self-employed individuals (i.e., sole proprietors, partners, and greater than 2% 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: _____ <small>(numbers should include affiliated employers, if any)</small>		
Will your plan include any affiliated employers? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please include affiliated employer information on page 4)		
Eligibility (must match eligibility for medical plan indicated on BCBSVT BEB 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



Northeast Benefits Management, LLC Application for Administration

COBRA Administrator name & address:	Email	Phone
-------------------------------------	-------	-------

Current Benefits

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

- | | |
|---|---|
| <input type="checkbox"/> HRA (Please provide a copy of your SPD)
<input type="checkbox"/> Section 125 Plan (Please provide a copy of your SPD) *
<input type="checkbox"/> Medical
<input type="checkbox"/> Dental
<input type="checkbox"/> Vision | <input type="checkbox"/> EAP
<input type="checkbox"/> Parking/Transit Account
<input type="checkbox"/> Health FSA
<input type="checkbox"/> Dependent Care FSA
<input type="checkbox"/> 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 received on the BCBSVT file feed)

Plan Effective Date: _____ **Name of BRS Blue Edge Business (BEB) Plan:** _____

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

- Reimburse eligible expenses applied to the BEB plan's Medical & Rx deductible ONLY
 Reimburse *all* eligible BEB plan's Medical & Rx out of pocket expenses, such as deductibles, copays and coinsurance

***Required:** Maximum HRA benefit for Single: \$ _____ 2 Person: \$ _____ Family: \$ _____

- A. 100% HRA from First Dollar
 Include an Rx Debit Card (pays 100%)
- B. 50% HRA from First Dollar (HRA pays at 50% of each claim)
 Include an Rx Debit Card (pays 50% or 100%, please indicate or circle which percentage for debit card _____)
- C. 100% HRA after \$1,500/\$3,000 threshold is met (HSA compatible)
- D. 50% HRA after \$1,500/\$3,000 threshold is met (HSA compatible)
- E. Custom HRA Design (any deviation from the above 4 standard options) will be quoted separately. Please outline your custom plan design in the note section on page 4.

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 apply) No
- Do you want NBM to perform the HRA nondiscrimination testing? Yes (additional charges 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:



Northeast Benefits Management, LLC Application for Administration

<p>Will the HRA benefits be pro-rated for employees enrolling mid-year?</p> <p><input type="checkbox"/> No (participants will receive the full benefit regardless of enrollment date) <input type="checkbox"/> Yes (if yes, benefits will be pro-rated by number of months enrolled)</p>	<p>Will the HRA plan provide coverage for Domestic Partners?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><small>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.</small></p>
<p>Do you have a previous HRA with a roll-over funds provision? _____</p> <p>If yes, please forward the prior carriers roll-over report once your run-out has ended. (Additional fees apply)</p>	

Employer HRA Funding
<p>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.</p>

Banking Information	
<p>Please provide the bank account information for funding of your HRA and/or HSA accounts</p>	
Bank Name	Bank Address
Bank Phone	Account Type
Routing Number	Account Number
Person Authorizing	Phone Number
<p>Please confirm with your financial institution that there are no debit blocks on your account prior to the effective date of your NBM account.</p> <p>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.</p>	
Signature	Date



Northeast Benefits Management, LLC Application for Administration

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) <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability taxed as: (circle one) Partnership/Corporation/S Corp <input type="checkbox"/> Government or Church <input type="checkbox"/> Non-profit <input type="checkbox"/> Other		
Seek advice of your Accountant and also notify us of any changes to entity type or ownership that occurs (or is anticipated) during the plan year.		
An Employer may provide tax-free benefits to employees, former employees, retirees, and their spouses or covered tax dependents. Because self-employed individuals are <u>not</u> "employees," an Employer may <u>not</u> provide tax-free benefits to self-employed individuals (i.e., sole proprietors, partners, and greater than 2% 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? _____		
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. Custom plan designs are any deviation from the 4 standard options on page 2. Custom plans include those that reimburse expenses other than medical, multiple plan designs and/or multiple medical plans. Please call or email us if you have any questions or wish to discuss.

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, whether made by me (plan sponsor) or mandated by the DOL or IRS, may result in additional fees. Finalization of this application is contingent upon receipt of a signed Administrative Services Agreement, which will be provided separately.	
Signature	Date

Thank You for your Business!

