VANTAGEPOINT
BENEFIT ADMINISTRATORS
20 Blake Ave, Lynbrook NY 11563
516-599-2120 VantagePointBenefit.com

Please check the applicable service(s) requested:

- ☐ Healthcare Reimbursement Account (HRA)
- ☐ Flexible Spending Account (FSA)
- ☐ Transit Reimbursement Account (TRA)
- ☐ Health Savings Account (HSA)
- ☐ Premium Only Plan (POP)
- ☐ Payroll Outsourcing

CLIENT APPLICATION FOR SERVICES

1. Company Name: _____

2. Street Address (No P.O. Boxes): _____

   City, State, Zip: _____

3. Phone: _____ Fax: _____

4. Federal Employer Identification Number (must be 9 digits): _____

5. Business Entity Type:
   ☐ 'C' Corp. ☐ 'S' Corp. ☐ Limited Liability Company ☐ Partnership
   ☐ Sole Proprietorship ☐ Not-For-Profit ☐ Government -Entity or Church
   ☐ Other: _____

6. Principal Business Activity: _____

7. Contact Person: a) _____ Title: _____

   E-mail Address: _____

   b) _____ Title: _____

   E-mail Address: _____

8. Total number of employees: _____ Benefit Eligible Employees: _____

9. Additional Locations and/or Affiliated Employer Information: *If additional locations exist, please attach on a separate sheet of paper. Companies with common ownership may have one plan document with one company shown as the plan sponsor and other affiliated companies adopting the same plan. These companies may have different Federal ID numbers, locations and payroll sources.*

Legal name of Employer: _____ Tax ID: _____

Mailing Address: _____

Contact Person: _____ Title: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

10. Owners/Shareholders: *List names of owners and/or shareholders possessing more than 2% of the company (other than a 'C' corporation). Please note that people listed are not eligible to enroll in FSA/HRA/TRA programs (but generally can enroll in an HSA).*

_____

_____

11. Broker (if applicable): _____

Mailing Address: _____

Email: _____ Phone: _____

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

☐ **NEW PLAN OR** ☐ **TAKE OVER OR** ☐ **MID-PLAN YEAR TAKEOVER**

Start Date: _____ End Date: _____

Underlying Medical Plan Renewal Date: _____ Is the Medical Deductible: ☐ Plan Year ☐ Calendar Year

Is this a short plan year ☐ YES ☐ NO (If yes, next plan year must be a full 12-month plan)

Next Plan Year Start Date: _____ End Date: _____

If a Takeover, is VantagePoint processing claim run in? ☐ YES ☐ NO

HRA Benefits. The Plan shall reimburse Eligible Employees for the cost of Eligible Medical Expenses defined by Internal Revenue Code Section 213 and as further described below:

☐ Premium Only. Reimbursement for Individual Insurance Premium up to $_____/month.

☐ Comprehensive. All medical, dental, and vision expenses not otherwise covered by insurance (e.g., co-pay, deductible, etc.)

☐ Bridge. Only those expenses covered under insurance, but subject to a deductible.

- ☐ Benefits split between Employer and Employee as follows: _____
- ☐ Benefits under this Plan shall be paid BEFORE the employee is responsible for his portion of the deductible limit
- ☐ Benefits under this Plan shall be paid AFTER the employee's portion of the deductible limit is paid.

☐ Limited. Only those expenses not otherwise covered by insurance (e.g., co-pay, deductible, etc.), as further selected:

- ☐Medical _____
- ☐Dental _____
- ☐Vision _____
- ☐ Prescription Drugs _____
- ☐Other: _____

Can participants carry forward unused funds? ☐ YES ☐ NO Maximum Carryover: _____

**Note: No amount may be paid in cash or other form of distribution, other than reimbursement of actual expenses incurred.

HRA Contributions. Employees are entitled to:

- ☐ Complete HRA allotment on the 1st day of the Plan Year
- ☐ 1/12 of the HRA allotment on the 1st day of each month

If a participant enters mid-plan year, they receive: ☐ the full annual contribution ☐ a pro-rated contribution

FSA offered? ☐ YES ☐ NO Which pays first? ☐ HRA ☐ FSA

Underlying HSA offered? ☐ YES ☐ NO If Yes, HRA can only pay after the IRS determined HSA deductible

Debit cards (if applicable) can be used for: ☐ All Expenses ☐Rx Only ☐Other _____

FLEXIBLE SPENDING ACCOUNT (FSA)

☐ **NEW PLAN OR** ☐ **TAKE OVER OR** ☐ **MID-PLAN YEAR TAKEOVER**

2020 – Healthcare related reimbursement maximum - $2750
2020 – Dependent Care related reimbursement maximum - $2,500 single; $5,000 married

Start Date: _____ End Date: _____

Is this a short plan year? ☐ YES ☐ NO (If yes, next plan year must be a full 12-month plan)

Next Plan Year Start Date: _____ End Date: _____

Limited Purpose FSA: ☐YES ☐ NO
**Limited Purpose FSA is used for Dental and/or Vision expenses only when an HSA is also available.

Payroll Schedule: ☐ Monthly ☐ Semi-Monthly ☐ Weekly ☐ Bi-Weekly

1st Paycheck Date of the plan year: _____ 2nd Paycheck Date of the plan year: _____

Plan Year End Options:
Two and a half (2 ½) month Claim Extension ☐ YES ☐ NO **OR** Roll-Over Option up to $500 ☐ YES ☐ NO

-The extension gives participants up to 75 days after the end of the plan year to use prior year funds.

-The Roll-Over allows participants to carry over up to $500 of employee funds to be used in the following year.

FSA Contributions – The contributions for the FSA Plan will be:

☐**Employee Only** (salary reduction) contributions

☐**Employer Only** contributions. Employer Annual Contribution $ _____ per participant

☐**Both Employee and Employer contributions.** Employer Annual Contribution $ _____ per participant

Which pays first? ☐ Employer Funds ☐ Employee Funds

TRANSIT REIMBURSEMENT ACCOUNT (TRA)

☐ **NEW PLAN OR** ☐ **TAKE OVER OR** ☐ **MID-PLAN YEAR TAKEOVER**
2020 – Mass Transit maximum monthly pre-tax election – $270
2020 – Parking maximum monthly pre-tax election – $270

Start Date: _____

TRA Contributions– The contributions for the Transit Reimbursement Plan will be:

☐**Employee Only** (salary reduction) contributions

☐**Employer Only** contributions $ _____ **Employer** Contribution per Participant

☐**Both Employee and Employer contributions. Employer** Contribution $ _____ per participant per month

Employee POST-TAX Annual Contribution (maximum allowed) ☐ YES ☐ NO

Contribution Funding: Choose one: ☐ Concurrent with Payroll or ☐ One month in Advance

HEALTH SPENDING ACCOUNT (HSA)

Start Date: _____ Renewal Date: _____

Is the Underlying Deductible-based Health Plan a qualified HSA compatible plan? ☐ YES ☐ NO
Please provide copy of current plan document and summary plan description

Is Employer Contributing: ☐ YES ☐ NO If yes, please indicate amount, method and frequency:
_____

_____

Is Employee Contributing: ☐ YES ☐ NO If yes, please indicate method: ☐ ACH Payroll Deduction ☐ Check

Frequency: _____ (Pre-Tax payroll deductions must conform to Section 125 required guidelines.)

Projected number of participants? _____

PREMIUM ONLY PLAN (POP)

☐ **NEW PLAN OR** ☐ **TAKE OVER**

Start Date: _____ End Date: _____

Is this a short plan year ☐ YES ☐ NO (If yes, next plan year must be a full 12-month plan)

Next Plan Year Start Date: _____ End Date: _____

Number of existing participants: _____

Benefits – The coverages selected shall be included in the POP: ☐ Medical ☐ Dental ☐ Vision ☐ Cancer insurance ☐ Group-term life[1] ☐ Disability[2] ☐ Critical illness ☐ Accidental death/dismemberment ☐ Other (specify) _____

[1] Group-term life insurance up to $50,000 coverage

[2] If disability insurance is paid for on a pre-tax basis, any benefits received are taxable to the employee. Under most circumstances, it is recommended that disability insurance not be included in the plan. Note: Insurance products with a return-of-premium feature cannot be paid for on a pre-tax basis.

PAYROLL OUTSOURCING

Pay Cycle Dates:

Start Date: _____ End Date: _____ Initial Check Date: _____

Start Date: _____ End Date: _____ Second Check Date: _____

Start Date: _____ End Date: _____ Third Check Date: _____

Additional Details:

Preferred Entry Method: ☐ Web Submission ☐ Email Submission ☐ Phone Submission

Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Electronic Delivery: ☐ Yes ☐ No **OR** Hard Copy Delivery: ☐ Yes ☐No If Yes, to how many locations: _____

Time and Attendance Accrual Tracking: ☐ Yes ☐No General Ledger Interface: ☐ Yes ☐No

Third Party Deduction Transmittal: ☐ Yes ☐No If Yes, to which vendor? _____

ADDITIONAL COMPANY LEVEL DETAILS

1. Claims Funding:

   ☐ ACH transfer (money pulled as claims are submitted and processed, paid on VP check stock)
   ☐ Client Checks (reimbursement checks mailed to client for signature & distribution)

2. Debit Cards: ☐ YES ☐ NO Debit Card Fee: ☐ Employer Paid ☐ Employee Paid

   a. Debit Card Funding:

      ☐ Aggregate Funding (This method requires 10% - 25% of the total annual election amount as an ongoing minimum balance. Exact percentage depends on total annual election. Funding replenishment averages 50% of the minimum balance and is requested as required.)

      ☐ TPA Secured Funding (This method initiates a daily debit card usage pull on the client bank account provided. At the close of each day, the debit card transactions will be batched into one sum and pulled from the account the following day.)

3. Current eligibility/waiting period new hires need to satisfy before becoming eligible:

   _____ Days after Date of Hire (maximum of 90 days)

4. Once the employees are eligible, they can begin participating in the plan:

   ☐ Date employee becomes eligible.
   ☐ First day of month following the date employee becomes eligible.

5. When do benefits terminate (select only one):

   ☐ Date of Termination
   ☐ Last day of the Month

6. Are all Employees paid on the same Payroll Frequency? ☐ Yes ☐ No

   a. If No, please explain: _____

7. The following employees are **excluded** from the benefit plan (Mark all boxes that apply) :

HRA	FSA	TRA	
☐	☐	☐	Employees not eligible for Employer group medical plan
☐	☐	☐	Employees not enrolled in the Employer group medical plan
☐	☐	☐	Part-time Employees expected to work less than _____hours per week
☐	☐	☐	Union Employees
☐	☐	☐	Other _____

8. Grace period during which claims may be submitted after end of plan year: ☐ 90 days ☐ Other _____

9. Grace period during which claims may be submitted after employee termination: ☐90 days ☐ Other _____

PRICING INFORMATION*

Benefit	New Plan Setup or Plan Takeover	Monthly Minimum	Per Participant/ Per Month	Renewal Compliance	Debit Card Per Participant
Flexible Spending Account (FSA)	**Please refer to custom proposal**				
Heath Reimbursement Arrangement (HRA)	**Please refer to custom proposal**				
Health Savings Account (HSA)			☐ **EE Paid** ☐ **ER Paid**		
Transit Reimbursement Account (TRA)	**Please refer to custom proposal**				
Payroll Outsourcing	**Custom Quotes Only**				

*Multi-Line Discounts are Available.

AUTHORIZED SIGNATURES

Company	VantagePoint
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____