



SIGNIFICA BENEFIT SERVICES, INC.
Section 125 Plan Employer Application

For office use only: Date Received _____

Effective Date _____

Name: _____ **Telephone #:** _____ **E-Mail:** _____

General Employer Information

Employer Name (full legal name): _____			Contact Name: _____		
Street Address: _____			Contact Telephone #: _____		Contact E-Mail: _____
City: _____	State: _____	Zip Code: _____	Employer's Legal Structure:		
Mailing Address (if different from above): _____			<input type="checkbox"/> Sole Proprietorship (owner not eligible) <input type="checkbox"/> Partnership (partners not eligible) <input type="checkbox"/> S Corporation (2% or greater shareholders not eligible) <input type="checkbox"/> C Corporation <input type="checkbox"/> Other (specify): _____		
Telephone #: _____		Fax #: _____		Employer subject to COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tax I.D. #: _____		SIC Code: _____		Employer subject to FMLA: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Number of Payroll Periods: 12 24 26 52 Other: _____

General Plan Information

Types of Arrangements to be Included under the Plan <i>(check all that apply):</i> <input type="checkbox"/> Premium Only Account (POA) <input type="checkbox"/> Health Care Flexible Spending Account (HCFSA) <input type="checkbox"/> Dependent Care Flexible Spending Account (DCFSA)	New or Existing Plan <i>(check and complete as applicable):</i>	
	<input type="checkbox"/> New Plan	Requested Effective Date: _____
Plan Number: 5 _____	<input type="checkbox"/> Existing Plan	Original Effective Date: _____ Effective Date of Service Agreement with EGA: _____
	Plan Year: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Other: _____	Plan Document: <input type="checkbox"/> SBS to provide plan document <input type="checkbox"/> Employer to provide plan document Note: SBS will accept Employer provided document only if it is compliant will all applicable laws

Employer Chooses to Allow Annual Elections to be Revoked upon the Occurrence of the following Life Events

<i>(For each type of arrangement offered, place a check mark in the box beside each life event for which a change in election will be permitted)</i>	POA	HCFSA	DCFSA
<input type="checkbox"/> Same as existing plan (if applicable) or choose from the following:			
<input type="checkbox"/> Change in employee's legal marital status			
<input type="checkbox"/> Change in number of employee's tax dependents			
<input type="checkbox"/> Change in employment status of the employee, spouse, or dependent that affects eligibility			
<input type="checkbox"/> Change in a dependent's eligibility			
<input type="checkbox"/> Change in place of residence of the employee, spouse, or dependent		N/A	N/A
<input type="checkbox"/> Automatic change in employee's elective contributions due to a small cost increase or decrease		N/A	N/A
<input type="checkbox"/> Significant cost increase (with or without a loss of coverage)		N/A	
<input type="checkbox"/> Significant coverage curtailment		N/A	
<input type="checkbox"/> Addition or elimination of a benefit package option		N/A	
<input type="checkbox"/> Change in coverage under other employer's plan		N/A	
<input type="checkbox"/> COBRA events		N/A	N/A
<input type="checkbox"/> Judgment, decree, or order requiring coverage for a child or cancelling coverage for a child if another individual must and does provide coverage			N/A
<input type="checkbox"/> Medicare or Medicaid eligibility is gained or lost		N/A	N/A
<input type="checkbox"/> Loss of coverage under the group health plan of a governmental or educational institution		N/A	N/A

(Over)



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Premium Only Account Information (POA) (complete if offered under the plan)

Eligibility:	Waiting Period: _____	Hours Required for Eligibility: _____
	Other eligibility requirements (<i>specify</i>): _____	
Eligible Classes:	<input type="checkbox"/> All employees who satisfy eligibility requirements <input type="checkbox"/> All employees except (<i>specify</i>): _____	
Entry Date:	<input type="checkbox"/> Date conditions for eligibility are met <input type="checkbox"/> First day of the month following the date requirements for eligibility were met <input type="checkbox"/> Other (<i>specify</i>): _____	

Health and Dependent Care Flexible Spending Account (HCFSA) and (DCFSA) Information (complete if offered under the plan)

Eligibility:	Waiting Period: _____	Hours Required for Eligibility: _____
	Other eligibility requirements (<i>specify</i>): _____	
Eligible Classes:	<input type="checkbox"/> All employees who satisfy eligibility requirements <input type="checkbox"/> All employees except (<i>specify</i>): _____	
Entry Date:	<input type="checkbox"/> Date conditions for eligibility are met <input type="checkbox"/> First day of the month following the date requirements for eligibility were met <input type="checkbox"/> Other (<i>specify</i>): _____	

HCFSA Limits Each plan year, employees may reduce compensation by up to: \$ _____	Employer Contribution: <input type="checkbox"/> No <input type="checkbox"/> Yes - \$ _____	
	Employer contribution is for:	<input type="checkbox"/> Employee chooses how to allocate <input type="checkbox"/> HCFSA \$ _____ <input type="checkbox"/> DCFSA \$ _____ <input type="checkbox"/> Other \$ _____
	Timing of Employer DCFSA contributions (if applicable)	DCFSA contributions will be made available: <input type="checkbox"/> At the beginning of the plan year <input type="checkbox"/> Pro rata each pay period
	Cash out option available	<input type="checkbox"/> No <input type="checkbox"/> Yes (specify) \$ _____ per employee

Forfeitures:	<input type="checkbox"/> used to reduce premiums for the following plan year <input type="checkbox"/> used to offset reasonable administrative expenses <input type="checkbox"/> refunded to participants reasonably and uniformly, not based on claims experience
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First pay date for payroll deduction: _____	Funding Method: <input type="checkbox"/> MICR <input type="checkbox"/> Reserve <input type="checkbox"/> ACH transfers
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Last day for incurring HCFSA claims: last day of plan year *or* 2.5 months after end of plan year (grace period)
Deadline for filing claims (number of days following end of plan year): 90 120 Other (*specify*): _____

Last day for incurring DCFSA claims: last day of plan year *or* 2.5 months after end of plan year (grace period)
Deadline for filing claims (number of days following end of plan year): 90 120 Other (*specify*): _____

Debit Card Option: No Yes

ACH transfers must be used to fund the Debit Card Option. If the Debit Card Option is selected, an ACH Agreement must be completed and returned **with** this Application. In addition, the following information must be provided to assist with electronic point of service processing.

Group Health Plan Copays		Rx Plan Copays				
\$	Type: _____	Retail	Generic \$ _____	Preferred \$ _____	Brand \$ _____	Other \$ _____
\$	Type: _____	Maintenance	Generic \$ _____	Preferred \$ _____	Brand \$ _____	Other \$ _____
\$	Type: _____					
\$	Type: _____					

Employee Materials:	<input type="checkbox"/> mail to Employer for distribution to employees <i>or</i> <input type="checkbox"/> mail directly to employees (additional charges will apply)
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Signature of Employer's Authorized Representative

Name: _____ Date: _____



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ACH (Automated Clearing House) Agreement
AUTHORIZATION FOR ACH DEBITS/CREDITS

Depositor Name as Shown on Bank Records	
Depositor's Bank,	Address <i>(Street, Box Number, City, State, and Zip Code)</i>
Account Number <i>(Depositor Checking Account Number)</i>	ABA Number <i>(Transit Routing Number – always a 9-digit number)</i>
Tax I.D. #	

I (WE) HEREBY AUTHORIZE METAVANTE, LLC, M & I BANK, AND SIGNIFICA BENEFIT SERVICES, INC., FULTON BANK, P.O. BOX 4887, LANCASTER, PA 17604, TO INITIATE DEBIT AND CREDIT ENTRIES VIA AUTOMATED CLEARING HOUSE (ACH) FROM OUR ACCOUNT INDICATED ABOVE AT THE BANK NAMED ABOVE.

Depositor authorizes M & I Bank to present automated debits and credits via Automated Clearing House (ACH) to the above listed account related to processing stored value card settlements associated with Depositor's flexible spending account program. In addition, the depositor authorizes Significa Benefit Services, Inc. (SBS) to present automated debits and credits via Automated Clearing House (ACH) to the above listed account related to flexible spending account claims submitted and processed by SBS. This authorization will remain in effect until revoked by the Depositor in writing and until you actually receive such notice. Depositor agrees that you shall be fully protected in honoring any such ACH. Depositor is responsible for notifying the above bank of this authorization.

Depositor agrees that your treatment of such ACH and your rights in respect to it shall be the same as if it were a check signed by the Depositor.

Dated this _____ day of _____, 20_____

Signature of Depositor in Agreement with Bank Records
Print Depositor Name and Title

*****IMPORTANT NOTE*****
PLEASE ATTACH A COPY OF YOUR VOIDED CHECK WITH THIS FORM
----- *Attach voided check here* -----