



SIGNIFICA BENEFIT SERVICES, INC.
Section 125 Plan Employer Application

For office use only: Date Received _____ Effective Date _____

Broker Information			
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: <input type="checkbox"/> Sole Proprietorship (<i>owner not eligible</i>) <input type="checkbox"/> Partnership (<i>partners not eligible</i>) <input type="checkbox"/> S Corporation (<i>2% or greater shareholders not eligible</i>) <input type="checkbox"/> C Corporation <input type="checkbox"/> Other (<i>specify</i>):
Mailing Address (if different from above):			
Telephone #:	Fax #:		
Tax I.D. #:	SIC Code:	Employer subject to COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No Employer subject to FMLA: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Payroll Periods: <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> Other: _____			
General Plan Information			
Types of Arrangements to be Included under the Plan (check all that apply): <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 (check and complete as applicable):	
Plan Number: 5 ____		<input type="checkbox"/> New Plan	Requested Effective Date:
		<input type="checkbox"/> Existing Plan	Original Effective Date:
Plan Year: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Other: _____		Effective Date of Service Agreement with EGA:	
		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>			
<input type="checkbox"/> Same as existing plan (if applicable) or choose from the following:		POA	HCFSA
<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
<input type="checkbox"/> Automatic change in employee's elective contributions due to a small cost increase or decrease			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
<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
<input type="checkbox"/> Loss of coverage under the group health plan of a governmental or educational institution			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 (specify):					
Eligible Classes:	<input type="checkbox"/> All employees who satisfy eligibility requirements <input type="checkbox"/> All employees except (specify):					
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 (specify):					
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 (specify):					
Eligible Classes:	<input type="checkbox"/> All employees who satisfy eligibility requirements <input type="checkbox"/> All employees except (specify):					
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 (specify):					
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					
First pay date for payroll deduction:		Funding Method: <input type="checkbox"/> MICR <input type="checkbox"/> Reserve <input type="checkbox"/> ACH transfers				
Last day for incurring HCFSA claims: <input type="checkbox"/> last day of plan year or <input type="checkbox"/> 2.5 months after end of plan year (grace period)						
Deadline for filing claims (number of days following end of plan year): <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> Other (specify):						
Last day for incurring DCFSA claims: <input type="checkbox"/> last day of plan year or <input type="checkbox"/> 2.5 months after end of plan year (grace period)						
Deadline for filing claims (number of days following end of plan year): <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> Other (specify):						
Debit Card Option: <input type="checkbox"/> No <input type="checkbox"/> 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 \$ ____
\$	Type:					
\$	Type:					
Employee Materials:	<input type="checkbox"/> mail to Employer for distribution to employees or <input type="checkbox"/> mail directly to employees (additional charges will apply)					
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* -----