☐ FLEX ADMINISTRATION ☐ FLEX & COBRA ADMINISTRATION

PAYPRO ADMINISTRATORS

☐ Check if Employer offers HSA
☐ Check if HSA is offered Pre-Tax
☐ ER Contributions ☐ EE Contributions

○ Employer Acct (no dir deposit available w/this option)
○ BennyCards (TPA must have ability to ACH funds each cycle)
○ Dir. Deposit (TPA receive or ACH funds each paycycle before processing)

☐ Premium Only with annual renewal service
☐ Flex Spending Accts (HCFSA & DCFSA)
☐ DCFSA Only
☐ Other

Company Name

Address

City State Zip

Telephone Fax Federal Tax ID Number

Employer Entity:

☐ S Corp ☐ Corporation ☐ Partnership ☐ Sole Prop Other State of Incorporation _____

Note that 2%+ owners in an S-Corp, Partners in a partnership, members of an LLC and sole-proprietors may not participate in a Flex Plan.

Corporate President, Owner or Managing Partner	Corporate Secretary

Plan administrator contact (all plan info will be sent to this individual)	Phone	Email

Payroll contact name (reports info will be sent to this individual)	Phone number and Extension	Email

Is this a takeover? Yes ☐ No ☐	This will be Plan Number	This Plan will Start On (Date)	This Plan will End On (Date)	2 1/2 month Extension Option? *If not answered—NO* Yes ☐ No ☐

Select the benefits offered under the premium only portion of the plan: (check the benefits you offer)

☐ Health Ins. ☐ Dental Ins. ☐ Disability Ins. (if cost is pre taxed—then benefits are taxable)
☐ Vision ☐ Group-Term Life (up to 50k) ☐ Other_____ (voluntary plans should be listed)

More info about your benefits—please tell us what type of benefits you offer under your group plan:

☐ Health HMO ☐ Health POS ☐ Health PPO
☐ Dental DHMO ☐ Dental POS ☐ Dental PPO
☐ Vision ☐ Ortho Coverage

Are dependents eligible to to participate in these plans? ☐ yes ☐ no

About your Employees:	How Many Total EE's	# Of Benefit Eligible	# of Non English Speaking

Eligibility for HCFSA Flex Plan	Eligibility for DCFSA
Health Care FSA Eligibility (i.e. 90 days)	Dependent Care FSA Eligibility (i.e. 90 days)
HCFSA Contribution Limits $_____	DCFSA Contribution Limits $5000 maximum per year/
Participant can join the plan after meeting eligibility on	Participant can join the plan after meeting eligibility on
☐ First day of the Month ☐ First day of Plan Year	☐ First day of the Month ☐ First day of Plan Year

Paycycles: Please check the box for all cycles that apply to the employer

☐ Weekly 52 or 48 benefit pay days ☐ ?

☐ BiWeekly 24 or 26 benefit pay days ☐ ?

☐ Semi Monthly Dates _____

☐ Monthly Dates _____

Miscellaneous Information

Benefits Terminate Under this Plan ☐ End of Employment

Terminated Employee's may submit claims for reimbursement up to ☐ days after EOE

Participants may submit claims up to ☐ days after the plan year ends

☐ Short Plan Year?
Provide Dates of Short Plan Year

Funds will be collected from client:

- ☐ N/A—Client will utilize their own account (direct deposit not available with this option) (attach check of account)
- ☐ TPA will ACH funds (please complete the Authorization Agreement for Direct Payments)
- ☐ Client will forward funds each cycle (BennyCards not available with this option)

Reimbursements shall be made:

- ☐ Each payroll cycle, within 7 days after having received the payroll reports from the employer (standard—no addtl fee)
- ☐ Weekly (add $25 fee for each weekly cycle and note checks are forwarded to employer)
- ☐ In addition, if employer would like checks/direct deposits mailed to participant home addresses, fee is $1.50 pppm.

Account Statements shall be prepared:

- ☐ Quarterly (standard)
- ☐ Last cycle of the month
- ☐ Each cycle

Enrollment and Re-Enrollment Details

☐ Premiums Automatically Pre-Taxed ☐ Premium Enrollment Required

☐ Rollovers ☐ No Rollovers

Fees: *This section for PayPro Administrators Use Only*

_____One time set up fee	_____BennyCard One time set up fee	_____ER Monthly Fee
_____One time document fee	_____BennyCard PPPM Fee	_____STD FSA Fee
_____Plan Doc Change Fee	_____PPPM Fees Paid by ER EE	_____2 1/2 Ext Fee
_____Form 5500 Preparation	_____Discrimination Testing	_____Meeting Fee Per Day
_____Mailed Account Statements	_____Per Enroll Kit Fee	_____Addtl Process Fee

Other Fee Information—Please be specific:_____

_____

_____

_____

Broker Information:

Company/Agency Name _____

Broker_____

_____ _____ _____ _____

Address City State Zip

_____ _____ _____

Phone Fax Email Address

Attach authorization agreement for direct payments, fee schedule, discrimination worksheet (also attach benefit summaries if Benny-Cards are offered).

Return all information to :
PAYPRO ADMINISTRATORS
Attn: Sales Division
6180 QUAIL VALLEY COURT . RIVERSIDE, CA 92507
800.427.4549 . 951.656.9273 . 951.656.9276 fax

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