Pro-Flex
PRO-FLEX ADMINISTRATORS LLC

Parking/Transit Installation Questionnaire

EMPLOYER INFORMATION :

1. Employer (legal business name with correct punctuation): _____
   *(**NOTE:** A corporate name must end in "Incorporated", "Corporation" or "Limited", or an abbreviation of same)*

2. Street Address: _____

   City, State, Zip Code: _____

3. Contact Information:

	Contact #1	Contact #2	Contact #3
Name			
Title			
Phone			
Fax			
E-mail			

4. Tax ID Number:

		-							

5. Number of Eligible Employees: _____ Number of Employees World-Wide: _____

6. Type of Business Entity:

	Sole Proprietorship		Partnership or LLP
	Corporation		Non-Profit
	S- Corporation		LLC
	Government Entity		Other: _____

***Note:** The following individuals may not be in a Section 125 or Section105 plan:*
Sole Proprietors, Partners in a Partnership or an LLP, Shareholders in an LLC that is taxed as a Partnership and Shareholders in an S-Corp. that own more than 2% of the S-Corp.'s stock directly or through a related party.

7. Primary Industry: _____

8. Other than the entity identified in '1' above, please list the name, address and employer identification number of any other employers whose employees are to be eligible for this Plan:

NAME	ADDRESS	TAX ID

PLAN INFORMATION:

9. Plan Effective:

   ☐ New Plan – NEW Flexible Spending Account will go into effect: _____/_____/_____
   ☐ Plan Update/Amendment- Effective Date of the new documents: _____/_____/_____
   Effective date of original plan: _____/_____/_____

10. Plan number to be used: _____
   (If no plan number is requested, a default plan number 501 will be used)

11. Initial Plan Year: _____/_____/_____ to _____/_____/_____
   Sub-sequent Plan Year: ____/_____ to _____/_____

ELIGIBILITY:

12. Eligible employees:
   ☐ N/A - No exclusions
   ☐ Employees enrolled in medical plan only (skip to Plan Benefits section)
   ☐ The following employees are excluded from eligibility:
      ☐ Highly compensated employees
      ☐ Non-resident Aliens
      ☐ Employees in-eligible for the employer's health plan
      ☐ Salaried Employees
      ☐ Hourly Employees
      ☐ Leased Employees
      ☐ Union employees
      ☐ Employees who are regularly scheduled to work less than _____ hours per week
      ☐ Other – describe:_____
      ☐ Employees in the following job categories:_____

13. The minimum service requirement to participate:
   ☐ N/A - No minimum service requirement
   ☐ _____ days after date of hire
   ☐ _____ months after date of hire
   ☐ Other: _____

14. Upon completion of the above, the employee becomes effective:
   ☐ Immediately
   ☐ First of the month following
   ☐ Other: _____

PLAN BENEFITS:

15. Flexible Spending Account Options:

X	Account Type	Minimum Annual	Maximum Annual
	Parking Reimbursement Account	$	$ OR IRS Max
	Transit Account	$	$ OR IRS Max

16. Contributions to the FSA are made by:

☐ Employee salary reduction

☐ Employee salary reduction and Employer Contribution

CLAIMS SUBMISSION:

17. Will this plan allow for use of the Pro-Flex Payment Card?

☐ Yes ☐ No

If yes, what return address would you like used on the Pro-Flex Payment Card?

☐ Pro-Flex ☐ Employer

18. Claims filing deadline: _____ days after the service date

19. Payroll Cycle:

☐ Weekly ☐ Semi-Monthly

☐ Bi-Weekly ☐ Monthly

****Please circle all pay dates on attached calendars.**
Please note any pay dates that will not have a payroll deduction.**

Total number of payroll deductions: _____

20. First pay date of the new plan year: ____/_____/_____

21. Will the client require divisional reporting?

☐ Yes ☐ No

If yes, please list division names: _____

BANKING/FUNDING AND FEES:

22. How will the client remit fee payments to Pro-Flex Administrators, LLC?

☐ Manual Check

☐ ACH Withdraw *(Please complete the Pro-Flex Electronic Payment Authorization)*

23. For payment of claim reimbursements:

☐ Pro-Flex Administrators will ACH funds from the employer's bank account *(This is the only option for Debit Card clients-* ***Complete Bancorp ACH Authorization for Debits/Credits****)*

☐ Client will ACH funds to Pro-Flex's bank account *(Client will need Pro-Flex Banking Information-* ***additional costs will apply****)*

In both cases the employer will be provided with a listing of claims paid in a check register report

24. How often will claims be paid?

☐ Every business day *(This is option requires a 3% collateral deposit for debit card issuance)*

☐ Weekly on Monday *(This is option requires a 5% collateral deposit for debit card issuance)*

***Please note:** Signature on this document is an agreement to pay Pro-Flex Administrators LLC all applicable fees described in detail in the proposal. Failure to pay fees may result in a halt of implementation or claims reimbursements to employees. If implementation has already begun, and a change is made, amendment fees may apply.*

Group Signature: _____ Date:_____

BROKER INFORMATION:

Contact Name and Agency: _____

Contact Title: _____

Signature: _____ Date:_____

Submit to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221

Pro-Flex
PRO-FLEX ADMINISTRATORS LLC

2023

JANUARY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4
5	6	7	8	9	10	11

FEBRUARY

S	M	T	W	T	F	S
29	30	31	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	1	2	3	4
5	6	7	8	9	10	11

MARCH

S	M	T	W	T	F	S
26	27	28	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	1
2	3	4	5	6	7	8

APRIL

S	M	T	W	T	F	S
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	1	2	3	4	5	6

MAY

S	M	T	W	T	F	S
30	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3
4	5	6	7	8	9	10

JUNE

S	M	T	W	T	F	S
28	29	30	31	1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	1
2	3	4	5	6	7	8

JULY

S	M	T	W	T	F	S
25	26	27	28	29	30	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

AUGUST

S	M	T	W	T	F	S
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31	1	2
3	4	5	6	7	8	9

SEPTEMBER

S	M	T	W	T	F	S
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
1	2	3	4	5	6	7

OCTOBER

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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4
5	6	7	8	9	10	11

NOVEMBER

S	M	T	W	T	F	S
29	30	31	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	1	2
3	4	5	6	7	8	9

DECEMBER

S	M	T	W	T	F	S
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Pro-Flex
PRO-FLEX ADMINISTRATORS LLC

2024

JANUARY

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31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
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MARCH

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SEPTEMBER

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OCTOBER

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NOVEMBER

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DECEMBER

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AUTHORIZATION FOR ACH DEBITS / CREDITS

_____

Depositor Name as Shown on Bank Records

_____

Checking Account Number/ Transit Routing Number

(A voided check, letter from the bank verifying the account AND routing number or MICR spec sheet must be attached for this account)

TO: _____

_____

(Bank Address: Street, Box #, City, State and Zip Code)

Depositor authorizes The Bancorp Bank to present automated debits and credits to and from the above listed account as required to perform their responsibilities related to processing Depositor's benefit program. This authorization will remain in effect until revoked by Depositor in writing and until you actually receive such notice Depositor agrees that you shall be fully protected in honoring any such ACH transaction.

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

I authorize payments to be withdrawn daily or weekly as needed.

Dated this_____day of_____, 20_____.

_____

Signature of Depositor in Agreement with Bank Records

Please update your ACH filter (on the above reference account) to grant access to The Bancorp Bank. The Bancorp Bank identification number is: **1050006509**.

Electronic Payment Authorization

Pro-Flex Administrators LLC , provides benefit administration services to_____ and/or, one or more of its wholly owned subsidiaries.

_____ desires the flexibility to make payments for such services by electronic funds transfers (EFT) through the ACH Network.

Therefore, _____hereby (1) authorizes Pro-Flex Administrators LLC to receive payments for services by EFT, (2) certifies that it has selected the following depository financial institution, and (3) directs that all such electronic funds transfers be made as provided below:

Depository Institution Name: _____

Routing Transit Number: _____

Account Number: _____

ACH Payment Format: CCD will be used (Cash Concentration/Disbursement)

Company EFT Contact: _____

Company Telephone Number: _____

_____ acknowledges and agrees that the terms and conditions of all agreements with Pro-Flex Administrators LLC concerning the method and timing of payments for services shall be amended as provided herein.

Company will give thirty (30) days advanced, written notice to Pro-Flex Administrators LLC of any changes in depository financial institution or other payment instructions.

When properly executed, the Authorization will become effective fifteen (15) days after its receipt by Pro-Flex Administrators LLC.

NAME OF COMPANY: _____

BY: _____

TITLE: _____ DATE: _____