Pro-Flex
PRO-FLEX ADMINISTRATORS LLC

Flexible Spending Account 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 Pro-Flex Client – NEW Flexible Spending Account will go into effect: _____/_____/_____
Effective date of original plan: _____/_____/_____

☐ 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. Plan Year: _____/_____ to _____/_____

12. Will there be a short plan year?

☐ Yes ☐ No

If "Yes":

Short plan year begins_____/_____/_____ and ends _____/_____/_____

Are the plan min/max amounts to be pro-rated for a short plan year?

☐ Yes ☐ No

ELIGIBILITY:

FSA eligibility should mirror medical plan eligibility

13. Eligible employees:

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

14. The minimum service requirement to participate:

☐ N/A - No minimum service requirement
☐ _____ days after date of hire
☐ _____ months after date of hire
☐ Other: _____

15. Upon completion of the above service requirement, the employee becomes effective:

☐ Immediately
☐ First of the month following
☐ Other: _____

PLAN BENEFITS:

16. Flexible Spending Account Options:

X	Healthcare Account Type	Minimum Annual	Maximum Annual
	Healthcare Reimbursement Account (FSA)	$	$
	Limited Purpose Healthcare Reimbursement Account (LP FSA)	$	$
	Dependent Care Account (DCA)	$	$ 5000 (IRS Max)
	Premium Reimbursement Account	$	$
	Adoption Assistance Account	$	$

****Please note that Healthcare Accounts are subject to COBRA****

17. Will this plan allow funds to rollover for the Healthcare FSA(s)?

☐ Yes ☐ No

18. Does the employer offer a Health Savings Account (HSA)?

☐ Yes ☐ No

19. Contributions to the FSA are made by:

☐ Employee salary reduction ☐ Employee salary reduction and Employer Contribution

CLAIMS SUBMISSION:

20. 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

21. Does the employer offer a Health Reimbursement Account (HRA)?

☐ Yes ☐ No

If "Yes", please describe: _____

For plans where Pro-Flex Administrators, LLC is administering both the FSA and HRA, which plan should pay first?

☐ FSA ☐ HRA

22. Will the plan allow for the "Grace Period"?

☐ Yes ☐ No

If Yes, for how long: _____ days (*max is 75 days/a plan can't have the Grace Period and the $500 Rollover*)

23. Claims "run-out" period: _____ days (check all that apply)

☐ After the employee was last eligible ☐ After the grace period extension

☐ After the end of the plan year

MISCELLANEOUS:

24. 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 an FSA payroll deduction.****

Total number of payroll deductions: _____

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

26. Will the client require divisional reporting?

☐ Yes ☐ No

If yes, please list division names: _____

27. Would the client like Pro-Flex to conduct Discrimination Testing?

☐ Yes, Pro-Flex Administrators will conduct testing post-enrollment. **Additional charges may apply.* ☐ No

28. Does your plan offer the following benefits?

- ☐ Group Medical Insurance
- ☐ Long-Term Disability Insurance
- ☐ Group Dental Insurance
- ☐ Short-Term Disability Insurance
- ☐ Group Vision Insurance
- ☐ Accidental Death and Dismemberment
- ☐ HSA Contributions
- ☐ Critical Illness Insurance
- ☐ Group-Term Life Insurance
- ☐ Hospital Indemnity Insurance
- ☐ Cancer Insurance
- ☐ Cash In Lieu
- ☐ Voluntary Benefits
- ☐ Intensive Care Insurance
- ☐ Specified Health Event
- ☐ Personal Sickness Indemnity

BANKING/FUNDING AND FEES:

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

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

30. 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

31. 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)*

32. Will Pro-Flex be administering the run out on the current plan year?

☐ No, the current TPA will handle their own run-out period. *(Pro-Flex preference)*

☐ Yes, Pro-Flex will handle the current plan year run-out. *(Client to send Pro-Flex a final balance report once final claims have been paid)*

***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

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30	1	2	3	4	5	6
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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

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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
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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
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17	18	19	20	21	22	23
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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
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28	29	30	31	1	2	3
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FEBRUARY

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3	4	5	6	7	8	9

MARCH

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

APRIL

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28	29	30	1	2	3	4
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MAY

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JUNE

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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: _____