Health Savings 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_____ Approximate number of employees who will be opening an HSA:_____

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 Section 125 or Section 105 plan:*
Sole Proprietors, Partners in a Partnership or an LLC, 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. Health Spending Account will go into effect: _____/_____/_____

10. Plan Year: _____/_____ to _____/_____

PLAN BENEFITS:

11. Annual HSA employer contribution amount:
    - ☐ None
    - ☐ $_____ per employee
    - ☐ $_____ Single $ _____ Couple $_____ Family
    - ☐ Other $_____

    Employer contributions will be made:
    - ☐ Annually- On the first day of the plan year
    - ☐ Quarterly- On the first of the month each quarter for all plan years
    - ☐ Monthly- On the first of the month each month for all plan years
    - ☐ Other: _____

12. Will you be offering HSA Advance?
    ☐ Yes ☐ No
    What is the maximum amount a member should be able to access via HSA Advance? $_____

13. 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

14. Does the employer offer a Health Reimbursement Account (HRA)?
    ☐ Yes ☐ No
    If "Yes", please describe: _____

BANKING/FUNDING AND FEES:

18. How will the client remit fee payments to Pro-Flex Administrators, LLC:
    ☐ Manual Check ☐ ACH Withdraw
    (Client will need to complete EFT Authorization)

Client Signature: _____ Date: _____

***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 claim reimbursements t employees. If implementation has already begun, and change is made, amendment fees may apply.*

BROKER INFORMATION:

Contact Name and Agency: _____

Contact Title: _____

Signature: _____ Date: _____

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

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: _____