Adoption Agreement Checklist

Section: Employer Information

Name of Employer

_____
_____

Employer's Address
(Street)_____
(City)_____
(State)_____
(Zip)_____
(Telephone)_____
(Fax)_____

PHI Officer:
Contact _____

Email_____

Other Contact:
_____

_____

Employer's Tax ID No.
_____

Plan Number (501,502, 503 etc.)
_____

State of Legal Construction: Employer's Principal Office
_____

Employer Entity

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ C Corporation
- ☐ S Corporation
- ☐ Limited Liability Company
- ☐ Limited Liability Partnership
- ☐ Non-Profit Organization
- ☐ Professional Service Corporation
- ☐ Medical Corporation
- ☐ Governmental Entity or Church
- ☐ Other _____

Family and Medical Leave Act: Is the Employer subject to these provisions?

- ☐ No
- ☐ Yes

COBRA: Is the Employer subject to these provisions?

- ☐ No
- ☐ Yes

Reimbursement Checks are to be cut by….

☐ a. Employer based on a report
☐ b. Electronic Fund Transfer
☐ c. Employer through Payroll download

☐ d. Vantage Flex, LLC
Employer Bank Account Information needed

Bank Name: _____

Account Number: _____

Routing Number: _____

Micr Symbol: _____

Starting Check Number: _____

Employer Must Sign in the space below for scanning and uploading in the administration system for check production and mailing to the employees.

Administration Fees Paid By: Check all that apply

- ☐ Employer
- ☐ Active Participants
- ☐ Retirees with spend down options (HRA)
- ☐ Terminated Employees with spend down options (HRA)
- ☐ Active Employee ends plan Participation with spend down options (HRA)

FSA Section:

Plan Information

☐ New Plan

☐ Amendment and Restatement

Plan Year

Begins _____(month) _____(day)
Ends _____(month) _____(day)

Grace period of ____ additional ☐ Days
☐ Months following the end of each Plan Year
To incur claims (2.5 months or less)

Is first year a short Plan Year?

☐ Yes, beginning _____

☐ N/A

Effective Date(s) Initial Effective Date (Must use 4 digit year)

_____(month) _____(day) _____(year)

Effective Date(s) This Restatement (Must use 4 digit year)

_____(month) _____(day) _____(year)

Eligible Class of Employees

☐ Salaried Employees only

☐ Hourly Employees only

☐ All Employees except

- ☐ Commissioned Employees
- ☐ Union Employees
- ☐ Leased Employees
- ☐ Part-time Employees, expected to work less than _____ hours per week
- ☐ Seasonal Employees who regularly work less than ___ months per year (Not to exceed 6 months)
- ☐ Nonresident Aliens
- ☐ Employees not eligible under Employer's group medical plan

☐ Other:_____

Conditions for Eligibility (Premium Account)

_____ years after date of hire
____ days after date of hire
_____ months after date of hire

Conditions for Eligibility(FSA Account) if different than above.

____ days after date of hire
____ months after date of hire
____ years after date of hire

Entry Date

☐ the date the eligibility requirements have been met

☐ the same day as the Employer's group medical plan

☐ the first day of the pay period next following the date eligibility requirements have been met

☐ the first day of the next month following satisfaction of the eligibility requirements

☐ the first day of the month coinciding with or following the date the eligibility requirements are met

Contributions, Plan will provide for...

☐ Salary reduction contributions ONLY

☐ Employer contributions ONLY

☐ Both salary reductions AND Employer contributions

Employer Contributions, For each Plan Year, Employer will contribute...

☐ $_____ per Participant

☐ Discretionary

☐ See attached detailed schedule

☐ N/A

AND, the contributions shall be made...

- ☐ N/A
- ☐ At beginning of Plan Year
- ☐ Pro rata each pay period
- ☐ See attached detailed schedule

Salary Reduction Benefit Options, Plan to provide...

☐ Premium Conversion Plan Only

☐ Flexible Spending Accounts

- ☐ Health FSA
  - ☐ Minimum _____
  - ☐ Maximum _____
  Federal annual maximum $2500 as of 01-01-2013, employer may choose less
- ☐ Dependent Care Assistance Program

☐ Individual Insurance Premium Reimbursement Account

☐ Section 132 Parking and Transportation plans

AND, the Over All Salary reductions shall not exceed: $_____ (must not be more than the lowest paid eligible employee annual wage)

AND, the Salary reductions shall be made...

☐ a. Weekly
☐ b. Bi-Weekly
☐ c. Semi-Monthly
☐ d. Monthly
AND the first pay period of the plan year is: _____/_____/_____

Reimbursement Schedule ...

☐ a. Weekly
☐ b. Bi-Weekly
☐ c. Semi-Monthly
☐ d. Monthly
AND the first Reimbursement of the plan year is: _____/_____/_____

Reimbursement Order…

☐ a. HRA Paid First
☐ b. FSA Paid First

Premium Payments may be elected for...

☐ Group Health insurance
☐ Group-term life insurance
☐ Disability insurance
☐ Dental insurance
☐ Cancer insurance
☐ Vision insurance
☐ Accidental Death and Dismemberment insurance
☐ Prescription Drug Coverage

Are the health premium payments elected above self-insured by the Employer?

☐ Yes
☐ No

Terminated Employees shall...

☐ Continue contributions and reimbursements for the remainder of the Plan Year
☐ Cease contributions and reimbursements upon termination
☐ Continue or cease at Participant's election

OTC drugs to be reimbursed?

☐ Yes
☐ No

Accommodate Health Savings Accounts (HSAs); the health FSA will be limited to the following types of medical expenses...

☐ N/A or no limits on types of expenses
☐ Limited to expenses following the minimum deductible amount of not less than $1200 single or $2400 family
☐ dental & vision expenses only

Benefit Election Period shall be...

☐ _____ days prior to each Plan Year
☐ Established by Administrator in a nondiscriminatory manner

Is automatic enrollment for insured benefits provided under this Plan

☐ Yes
☐ No

Participants who fail to sign a new election form shall...

☐ Continue same elections as prior year
☐ Be considered to have elected not to participate for upcoming Plan Year
☐ Continue same elections as prior year only for insured benefits

Will Affiliated Employers execute this Plan

☐ N/A or No
☐ Yes
(Name)_____
(Street)_____
(City)_____
(State) _____
(Zip)_____
(ID No.)_____

Claims for Reimbursement must be filed within (this is the run-out)

_____ days following each Plan Year

_____ days following date of termination of employment

_____ days following date Active Employee ceases to be a participant

_____ days following date Grace Period ends

Fee Schedule…

Setup	_____
Annual	_____
Monthly/participant	_____
5500 Fee	_____

Agent Name_____

Agent Phone #_____

HRA Section: This section allows for employer contributions ONLY!

Plan Information

☐ New Plan

☐ Amendment and Restatement

Plan Year

Begins _____(month) _____(day)
Ends _____(month) _____(day)

Is first year a short Plan Year

☐ Yes, beginning _____

☐ N/A

Effective Date(s) Initial Effective Date (Must use 4 digit year)

_____(month) _____(day) _____(year)

Effective Date(s) This Restatement (Must use 4 digit year)

_____(month) _____(day) _____(year)

Eligible Class of Employees

☐ Salaried Employees only

☐ Hourly Employees only

☐ All Employees except

- ☐ Commissioned Employees
- ☐ Union Employees
- ☐ Leased Employees
- ☐ Part-time Employees, expected to work less than _____ hours per week
- ☐ Seasonal Employees who regularly work less than ___ months per year (Not to exceed 6 months)
- ☐ Nonresident Aliens
- ☐ Employees not eligible under Employer's group medical plan

☐ Other:_____

Conditions for Eligibility

☐ For all years, eligibility is as follows:
_____ years after date of hire
____ days after date of hire
_____ months after date of hire

☐ Enrolled in the Employer's Group Health Plan

Entry Date

☐ the date the eligibility requirements have been met

☐ the same day as the Employer's group medical plan

☐ the first day of the pay period next following the date eligibility requirements have been met

☐ the first day of the next month following satisfaction of the eligibility requirements

☐ the first day of the month coinciding with or following the date the eligibility requirements are met

Employer Contributions, For each Plan Year, Employer will contribute...

☐ $_____ per Participant

☐ Discretionary (will provide a schedule)

AND, the contributions shall be made...

☐ At beginning of Plan Year

☐ Pro rata each pay period
- ☐ a. Weekly
- ☐ b. Bi-Weekly
- ☐ c. Semi-Monthly
- ☐ d. Monthly

AND the first pay period of the plan year is: _____/_____/_____

Reimbursement Schedule ...
- ☐ a. Weekly
- ☐ b. Bi-Weekly
- ☐ c. Semi-Monthly
- ☐ d. Monthly

AND the first Reimbursement of the plan year is: _____/_____/_____

Reimbursement Order…
- ☐ a. HRA Paid First
- ☐ b. FSA Paid First

Plan will reimburse...

☐ a. All Section 213 eligible expenses.
☐ b. Core expenses only
☐ c. Core health insurance deductible only
☐ d. Other_____

OTC drugs to be reimbursed?

☐ Yes

☐ No

Plan will reimburse at the rate of ...

- ☐ a. 100% of eligible expenses.
- ☐ b. 50% of eligible expenses
- ☐ c. ___% of eligible expenses
- ☐ d. other_____

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Roll Options - Employees have the option to...

- ☐ Roll all funds left in the account at the end of the year.
- ☐ Roll ___% of the funds.
- ☐ Roll ___% of the funds to a maximum of $_____.
- ☐ N/A No funds will roll.

Retirement Class

☐ Establish a retired class of employees

- ☐ Spend down for retired employee
- ☐ Contribution for retired employee

Amount of annual contribution:
$_____

Accommodate Health Savings Accounts (HSAs); the HRA will be limited to the following types of medical expenses...

☐ Limited to expenses following the minimum deductible amount of not less than $1200 single or $2400 family

☐ dental & vision expenses only

Terminated Employees shall...

☐ Forfeit all funds following the run-out
☐ be allowed to spend down the funds
☐ be allowed to roll the funds into an HSA

Will Affiliated Employers execute this Plan

☐ N/A or No

☐ Yes

(Name)_____
(Street)_____
(City)_____
(State) _____
(Zip)_____
(ID No.)_____

Claims for Reimbursement must be filed within (this is the run-out)

_____ days following each Plan Year

_____ days following date of termination of employment

_____ days following date Active Employee ceases to be a participant

Fee Schedule…

Setup	_____
Annual	_____
Monthly/participant	_____
5500 Fee	_____

Agent Name_____

Agent Phone #_____

Additional Notes:

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HSA Section:

Eligible Class of Employees

- ☐ Salaried Employees only
- ☐ Hourly Employees only
- ☐ All Employees except
  - ☐ Commissioned Employees
  - ☐ Union Employees
  - ☐ Leased Employees
  - ☐ Part-time Employees, expected to work less than _____ hours per week
  - ☐ Seasonal Employees who regularly work less than ___ months per year (Not to exceed 6 months)
  - ☐ Nonresident Aliens
  - ☐ Employees not eligible under Employer's group medical plan
- ☐ Other:_____

Conditions for Eligibility

☐ For all years, eligibility is as follows:
_____ years after date of hire
_____ days after date of hire
_____ months after date of hire

Entry Date

☐ First day of the pay period next following date requirements were met

☐ Date conditions for eligibility are met

☐ Dual entry

☐ First day of Plan Year following date requirements were met

☐ First day of month following date requirements were met

Contributions, Plan will provide for...

☐ Salary reduction contributions ONLY

☐ Employer contributions ONLY

☐ Both salary reductions AND Employer contributions

Employer Contributions, For each Plan Year, Employer will contribute...

☐ $_____ per Participant

☐ Discretionary

☐ N/A

AND, the contributions shall be made...

☐ At beginning of Plan Year

☐ Pro rata each pay period

☐ N/A

AND, the Salary reductions shall be made...

☐ a. Weekly
☐ b. Bi-Weekly
☐ c. Semi-Monthly
☐ d. Monthly
AND the first pay period of the plan year is: _____/_____/_____

Reimbursement Schedule ...

☐ a. Weekly
☐ b. Bi-Weekly
☐ c. Semi-Monthly
☐ d. Monthly
AND the first Reimbursement of the plan year is: _____/_____/_____

☐ N/A Employee claim Adjudication and Reimbursement.

Fee Schedule…

Setup	_____
Annual	_____
Monthly/participant	_____
5500 Fee	_____

Agent Name_____

Agent Phone #_____

Additional Notes:

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