INTEGRATED BENEFITS ADMINISTRATION

Premium Only Plan, Flexible Benefit Plan or HRA Employer Set-Up Sheet

Today's Date: ______________________________ Plan Effective Date: ______________________________________

Legal Company Name: ____

Business Type: ☐ C Corp ☐ S Corp ☐ Partnership ☐ LLC ☐ LLP ☐ Sole Proprietor

Phone: ______________________ Fax: ________________________ Email: ____________________________________

Address: ____ City: ________________ State:________ Zip: __________

Type of Plan: ☐ P.O.P. Plan ☐ Flexible Benefits Plan ☐ Dependent Care Reimbursement ☐ HRA

Insurance Plans to Be Included: ☐ Life ☐ Health ☐ Dental ☐ Vision ☐ Disability ☐ Other _______________

Eligibility Requirement: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other: _____________ (***Max of 365 Days***)

Pay Frequency: ______________________ Date of First Qualified Pay Period: __________________________

Plan Year: ___________________________ Flex Plan Maximum: $_______________________

Forfeitures Related to Flex Plan will be:

☐ Held in Reserves ☐ Distributed to Remaining Participants ☐ Allocated to Current Year Participants

Employer Contribution Amount (if applicable): $______________________

Key or Highly Compensated Employees:

____

HRA Specifications: ____

____

____

HRA Group Total: $___________________________ Per Employee Amount: $___________________________

Federal T.I.N.: ______________________________ Year of Incorporation: ______________________________

Bank Name: _________________________________ Branch: ____

Contact Name: ______________________________ Phone: ____

ABA#: _____________________________________ DDA#: ____

Signature: __________________________________ Date: ____

Printed Name: ______________________________ Title: ____

IBA Representative: __________________________ Agent/Broker: ____________________________________

Set-Up Fee: $_______________________________ Administration Fee: $_______________________________

INTEGRATED BENEFITS
ADMINISTRATION

New Business Transmittal

Group Name	E.I.N of Group	Per Pay Period Frequency
Plan Year	**E-mail Address**	**Contact**
Address	**City**	**Zip Code**
Phone Number	**Fax Number**	**Today's Date**
Plan Type	**Carry Over % on HRA Dollars**	**Employer Contribution to FSA**
HRA Plan Design	**Buy-Down Design**	**Annual FSA Limit or Cap**
Four Months Pay Periods Deposit	**One Time Set Up Fee**	**COBRA Support Service**
Debit Card Option	**Monthly Service Charge**	**Writing Agent/Broker Name**
	IBA Use Only	
Date of Complete Reception	**Date Processing Began**	**Date Processing Complete**
Date of Group Phone Call	**Date Participants Were Entered**	**Date Cards Were Activated**
Date Group Letter Was Shipped	**Date Employee Letter Shipped**	**Date Set Up Fee Received**
Date Group Admin. Kit Shipped	**Misc. Notes**	**Date Deposit Received**
Ancillary Enrollment Completion	**Ancillary Enrollment Ship Date**	**Ancillary Product Commission**
Agent Commission	**GA Commission**	**Broker/Producer Thank You Note**

INTEGRATED BENEFITS
ADMINISTRATION

Service and Facilitation Agreement

This agreement between ____ and Integrated Disability Management, Inc.
(Client Name)
d/b/a Integrated Benefits Administration an Idaho corporation is dated __________________________, 20____ and sets forth an understanding between the two entities. IBA will be referred to as we and the client shall be referred to as client.

This agreement is with respect to ongoing service of the client and their Flexible Spending Account under Section 125 of the IRS code as well as any similar plans related to other areas of the Internal Revenue Service code including but not limited to Section 105, Section 213D, Heath Reimbursement Arrangements, and Section 125 Dependent Care Plans.

This agreement does not change the responsibilities of the client or employer as related to facilitation of a Section 125, Section 105 or Section 213D plan.

Understanding

The client is the Plan Administrator for the Section 125, Section 105 and Section 213D (if applicable) plans. IBA is contracted to help the client fulfill their responsibilities as Plan Administrator by supplying the services listed below. Client acknowledges that IBA has no discretionary authority or control with respect to management or administration of the plans, dispensation of assets/funds, and investment of funds remitted to IBA and that the client is acting solely at its discretion.

As an agent for the client, IBA will accept direction from the client regarding reception of payments from the client and processing payments under the corresponding plan. **IBA shall only be responsible for processing requests for reimbursement to the extent the client has deposited sufficient funds in its *own account* to cover reimbursement to the employee or member. *IBA will not be expected to extend its own funds in the payment of Flex, HRA or other plan reimbursements*.**

Facilitation Services Provided by IBA to the Client:

- Provide Plan Documents, including a Summary Plan Description, for possible review by the client and or legal council for prior to adoption by the client. Client and or their counsel are solely responsible for review and revision prior to signing and implementation.
- Provide information to employee participants as to how each plan operates their rights and responsibilities.
- Offer to hold informational seminars for in person description of benefits, services and methods for reimbursement.
- Deliver election forms and estimation pages to each eligible employee.
- Deliver confirmation letters to each employee electing to enroll in one or more of the plans.
- Offer a variety of mechanisms for reimbursement of qualified expenses; including but not limited to: conventional mail or fax forms, physical address for in person delivery and a 24/7 web engine for electronic submission with paper substantiation.
- Offer to provide instructions for reimbursement requests.
- IBA will provide weekly reimbursement checks to the employee for reimbursement requests faxed to our office or submitted via the web engine.
- IBA will provide a quarterly and annual account statement for each employee.

Provide forms for use in day to day plan administration by the client including but not limited to:

Employee Add/Termination Form Salary Redirection Agreement

Claim Forms

- IBA will facilitate reimbursement requests subject to the regulations of the IRS and/or client direction.
- We will provide the option of seminars, prior to the following year's enrollment, to educate employees on how each plan will be facilitated.

Responsibilities of the Client

- Distribute the necessary forms and all other applicable documents provide by IBA or the IRS.
- Report participation changes and family status changes to IBA within ***48 hours of the change event***.
- Reconcile payroll amounts direct to each plan or IBA based on reports available from IBA.
- Provide, in a timely manner, to IBA such items such as employee census, payroll data and other reasonable and necessary information required to service the plan.

Indemnification

IBA indemnifies and holds harmless client from any and all losses and liabilities resulting from any breach of IBA's responsibilities and duties provided under this agreement.

Client indemnifies and holds harmless IBA from any and all losses and liabilities resulting from the client's breach of responsibilities and duties provided under this agreement and Section 125, 105 and 213D of the Internal Revenue Service Code.

All reimbursement requests submitted to IBA are assumed to be authorized by the client and client agrees to indemnify IBA against any and all losses and liabilities resulting from payment of claims processed as provided for in this agreement.

Fees and Payment

At the 1st of each month IBA will submit a statement to the client showing IBA fees for service during that month. Employer agrees to pay such fees within ***48 hours of receipt*** of this statement. Employer hereby authorizes and requests IBA to effect payment for any amounts owing by Client to IBA as such amounts become due by initiating debit entries to Client's account as identified.

The below listed fee schedule will apply for the benefit year ________________________.

This benefit year will start on ______________________________ and end on _______________________________.

One Time Set Up Fee: $__________________________

Per Employee Per Month: $__________________________

Terms of Agreement

This agreement will be effective as of the date of signature and shall continue from month to month until it is terminated by ***30 days*** *advance written notice by either IBA or the client.* ***In the event the client elects to terminate this agreement the effective date of termination will be the first day of the month following written notice of termination. All fees incurred during the time this agreement was in effect will be due upon written request to cancel.***

IBA	***Client***
By: Keith S. Paduch	By: ______________________________
Its: President/Owner	Its: ______________________________
Signature: _________________________	Signature: _________________________
Date: _____________________________	Date: _____________________________

INTEGRATED BENEFITS
ADMINISTRATION

Check Printing Request Authorization Form

Group Name: ____

We, the above listed Employer Group, are requesting and authorizing Integrated Benefits to print checks related to manual reimbursements against our FSA or HRA on our bank account. These checks will then be forwarded to our group (in bulk) for signature and distribution.

Business Name Associated with this Account: ____

Address of Business: ____

City: ______________________ State: ______________________ Zip Code: __________________

Return Address: ____

City: ______________________ State: ______________________ Zip Code: __________________

Routing Number: ____

Account Number: ________________________________ Beginning Check #: ________________

ABA Routing Number: ____________________________
(***This is Not the same as the routing number***) ***92-372/1234 3655*** (**for example**). ***Some banks still use this number. Please check with your Individual Banking Institution to see if they utilize the ABA.***

(Contact IBA if you have questions on this @ 208.287.0310)

Bank Name: ____

Bank Address: ____

Is this a Sub Account of another Account? ☐ Yes ☐ No

Account type: ☐ Checking ☐ Savings ☐ Money Market

Tax ID Number Associated with this Account: ____

Authorized Person Name: ____

Signature: ____ **Date:** ________________

INTEGRATED BENEFITS
ADMINISTRATION

ACH Debit Authorization

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS
(ACH DEBITS)

Company Name: **INTEGRATED DISABILITY MANAGEMENT**

Company ID Number: 1-260404651

I (we) hereby authorize **Integrated Disability Management, Inc. d/b/a/ Integrated Benefits Administration** hereinafter called COMPANY, to initiate debit entries to my (our) ☐ Checking Account / ☐ Savings Account (***select one***) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository
Name: ________________________________ **Branch:** ____________________________

City: __________________________________ **State:** ______________ **Zip:** __________

Routing Number (9 *Digits):* ______________________ **Account Number:** ____________________________

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s): ___________________________________ **Individual ID Number:**______________
(Please Print) *(To be completed by Company)*

Signature: ___________________________________ **Date:** ______/______/______

Please attach a VOIDED CHECK to this authorization if a checking account will be debited.

The routing and account numbers may be in different places on your check.