AMERICAN BENEFITS GROUP

Empowering Technology. Exceptional Service.

CLIENT INFORMATION FORM – *San Francisco HCSO HRA*

Company Profile

Legal Name of Organization: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Executive Officer: _____ Title: _____

Telephone: _____ Fax: _____

Email Address: _____ Company URL: _____

Business Activity: _____ Under Laws of (State): _____

Employer Fed Tax ID#: _____ Date of Incorporation: _____

Tax Year Start Date: _____ End Date: _____

Affiliated Employers *(if any)*: _____

Organization Type *(please check)*:

- ☐ Non-Profit
- ☐ Partnership/LLP*
- ☐ LLC *(Limited Liability Company)**
- ☐ Sub-chapter "S" Corporation*
- ☐ Professional Association
- ☐ Government Agency
- ☐ Sole Proprietorship*
- ☐ Sub-chapter C-Corporation*

* **Note**: Subchapter S Corporation shareholders above the 2% level **may not** participate, but they may sponsor a plan for their employees. In addition, family members and close relatives of these shareholders **may not** participate.

C-Corporation owners can participate and sponsor a plan.

LLC, LLP and Sole Proprietors **may not** participate, but may sponsor a plan for their employees. However, if the spouse is a bona fide employee of the firm, he or she may participate and use the benefit for the entire family.

Primary Contact Information

HR Contact: _____ Title: _____

Telephone: _____ Email: _____

Authorized for access to HR website? ☐ Yes ☐ No Backup Contact: _____

Payroll Contact: _____ Title: _____

Telephone: _____ Email: _____

Authorized for access to HR website? ☐ Yes ☐ No Backup Contact: _____

Finance Contact: _____ Title: _____

Telephone: _____ Email: _____

Authorized for access to HR website? ☐ Yes ☐ No Backup Contact: _____

Billing Contact *(for invoices)*: _____ Title: _____

Telephone: _____ Email: _____

Authorized for access to HR website? ☐ Yes ☐ No Backup Contact: _____

AMERICAN BENEFITS GROUP

REIMBURSEMENT ACCOUNTS FUNDING AGREEMENT

☐ New Account ☐ Change of Account

Effective Date: _____

American Benefits Group does not hold Flexible Spending Account funds for our clients, and no payroll deductions should be sent to American Benefits Group. Our funding mechanism for the reimbursement of your plan participants' claims requires that you, the client, provide American Benefits Group and the debit card company MBI (M&I) Bank, with authorization to draft funds from your designated bank account. It is your responsibility to ensure that said account is funded adequately. By completing the form below you are authorizing American Benefits Group to draft funds from your designated bank account to reimburse your participants' claims. Please check and sign for each reimbursement method that you are authorizing: Debit Cards; Direct Deposit; Check.

Authorized Bank Account Information

We _____ by signing next to the methods of reimbursement below, authorize American Benefits Group to reimburse claims by drafting funds from:

Bank Name _____

Routing #: ☐☐☐☐☐☐☐☐☐ Account #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please attach a VOIDED copy of the account holder's check.

Reimbursement Methods: As an employer sponsoring Reimbursement Accounts for your employees the following Reimbursement Methods are available to you:

☐ **ABG Benefits Card Replenishments:**

Debit card transactions make funds available to your plan participants with the swipe of a card. The funds for these card swipes will be drafted from your designated employer bank account on a daily basis, a daily email will be sent to you advising you of this transaction. Please note that when the bank account is initially set up there will be a pre-authorization transaction of $1.00 initiated by the debit card company; this pre-authorization is a requirement of the debit card issuing company to verify the account information. Debits will show as **M&I Bank** or **Med-I-Bank** and the Company ID is **1383261866.**

Card will be available for the following FSA Plans:

☐ Health FSA ☐ DCAP ☐ Commuter Transit ☐ Commuter Parking

Card will be available for the following HRA Expenses:

☐ RX ☐ 213D expenses

By signing below you are confirming that your bank will allow transactions with **ID:1383261866** labeled as: M&I Bank or Med-I-Bank.

_____

Signature of Authorized Signer on Bank Account

_____

Printed Name

☐ **Bank Draft Paired with Direct Deposit to Participant:**

Manual claims will be reimbursed once a week, the funds will be drafted from your authorized bank account and will be directly deposited to the participant's authorized bank account. These drafts will display on the employer's bank statement on Wednesdays labeled as American Benefits Group Claim Pmt with a company ID of **9165530001.**

By signing below you are confirming that your bank will allow transactions made by American Benefits Group with **ID: 9165530001** labeled as: Claim Pmt .

_____

Signature of Authorized Signer on Bank Account

_____

Printed Name

☐ **Check Reimbursements:**

In the event that all of your reimbursement account participants will not be providing Direct Deposit Authorization for manual claim reimbursements, you can agree to have American Benefits Group issue these reimbursements as checks. These checks will be issued from your authorized bank account using the signature of your authorized signer and available starting check numbers that you provide in section below. American Benefits Group provides the check stock needed for writing these checks, you may find a sample in the ***Administrator's Guide***. In the case that an employee loses or destroys a check, American Benefits Group will contact you, it is the Employer's responsibility to stop payments on lost or damaged employee checks. Once the check payment has been stopped, ABG will issue the employee a new check.

An image of the signature entered in the box to the right, will be printed on all checks issued pursuant to this agreement. Checks will be issued using the following starting check number . . .

Signature of Authorized Signer on Bank Account

_____

Printed Name

Either the Company or the Client may terminate this agreement at any time by a notice in writing, mailed to or delivered at the last known address of the other party, and that any payments due at the date of such termination, or thereafter falling due, shall be payable by the Client in accordance its obligations as Administrator under its Reimbursement Plan(s).