



SelectAccountSM

For Office Use Only:

SelectAccount Group Number _____

Enrollment Specialist _____

HEALTH SAVINGS ACCOUNT (HSA) PLAN DESIGN GUIDE

Please fill out this form in its entirety and return to SelectAccount 45 days in advance of your effective date in order for us to properly administer your plan. If you have any questions on how to complete the form, please call our Group Leader Line at 1-888-460-4013 or our Agent Service Line at 1-888-460-4015. If you are a 51+ age group, please contact your account manager. When complete, either fax form to (651) 662-1180 or toll-free at 1-866-231-0214, or mail to SelectAccount, PO Box 64193, Saint Paul, MN 55164. **Incomplete forms will be returned to you resulting in delays.**

I. EMPLOYER INFORMATION

Employer's Name _____

Employer's Street Address _____

City _____ State _____ Zip Code _____

Employer's Tax I.D. Number _____ Nature of Business _____

Type of Corporation S Corporation* C Corporation Partnership* Sole Proprietor*
 Political Subdivision/Church LLC* Other _____

**Subject to IRS Notice 2005-8 which provides guidance on a partnership's contributions to a partners HSA and an S Corporation's contributions to a 2% shareholder-employee's HSA.*

Number of Employees Eligible for Plan: _____

Person Responsible For Authorization of Plan Design:

Name _____ Title _____

Phone Number () _____ Fax Number () _____

Email Address _____

Main Contact Person _____ Title _____

Phone Number () _____ Fax Number () _____

Email Address _____

II. HSA REQUIREMENTS

Both statements in this section must be certified "yes" for the HSA to be properly established. **YES NO**The employer makes available a High Deductible Health Plan (HDHP), as defined in IRS Section 223(c)(2). The employer agrees to comply with the Federal HSA requirements.

III. TAKEOVER INFORMATION

Is SelectAccount taking over administrative services from another HSA administrator? Yes No

If yes, participants who wish to transfer dollars are required to complete the HSA Application (F7315) and the Transfer Request Form (F7320).

IV. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health plan carrier Blue Cross and Blue Shield of Kansas

Health plan group # _____

Are health plan accumulations calendar year or plan year? Calendar Year Plan Year

If you checked plan year, please indicate plan year start date _____ end date _____

V. HEALTH SAVINGS ACCOUNT OPTIONAL FEATURES

You may select any of the features listed below that best meet your needs and those of your participants. *Additional fees apply. Please refer to the fee schedule.*

Crossover

Medical Crossover

Eligible health plan expenses (i.e. deductible and/or coinsurance) as indicated on the Explanation of Benefits, will be electronically transferred to SelectAccount. If crossover is elected, pharmacy access will be point of sale. Claims will be processed and reimbursed according to the participant's available balance. Please note, crossover is not appropriate for participants who have secondary insurance coverage with Blue Cross or another carrier. *(This feature is only available if health plan is with Blue Cross and Blue Shield of Kansas)*

- Select one: Automatically enroll all participants in medical crossover. *(Participants may opt out by completing medical crossover form F7856.)*
 Offer medical crossover to participants. *(Participants may elect crossover by completing the medical crossover form F7856. Highest participant fee applies. Please refer to the fee schedule)*
 Do not offer medical crossover to participants. Highest Participant fee applies. Please refer to the fee schedule.

Debit Card

This optional feature allows a participant to use a debit card to access the HSA at point of service. If a participant elects the debit card option, crossover is no longer available. **Additional fees apply. Please refer to the fee schedule.**

- Offer debit card to participants. Participants may elect the debit card by completing form F8936.
 Do not offer debit card to participants

VI. ADMINISTRATIVE FEES

For participants who have an HSA stacked with a SelectAccount FSA, only the SelectAccount FSA fees will apply. The HSA participant fee will be waived. Debit card fees still apply.

Health Savings Account Plan Options

SelectAccount offers three different options for HSA Accounts. *(The fees and account interest rates are listed on form F9145 and are subject to change.)*

Please select one HSA plan option: HSA Thrift Saver HSA Basic Saver HSA Premium Saver

Participant Fees *(Participant fees apply only to HSA Basic Saver and HSA Premium Saver plan options)*

- Employer Paid
Indicate billing frequency: annually monthly
(If employer paid, billing frequency must match employer paid debit card billing frequency.)
 Participant Paid *(Billed annually and taken from participant's account balance.)*

Debit Card Fees *(Debit card fees apply to all HSA plan options, if debit cards are offered to employees)*

If you are offering debit cards to your employees, please complete this section:

- Employer Paid
Indicate billing frequency: annually monthly
(If employer paid, billing frequency must match employer paid participant fee billing frequency.)
 Participant Paid *(Billed annually and taken from participant's account balance.)*

VII. CONTRIBUTION INFORMATION

HSA's will be funded by: (Check **all** that apply)

- Employer Contributions
- Employee Payroll Deducted Contributions, Pre-Tax (only available when the HSA is part of a cafeteria plan)
- Employee Payroll Deducted Contributions, Post-Tax

HSA contribution amounts will be submitted to SelectAccount via: (select **only one**)

- ACH (If funding by ACH, it is required that you submit contribution information via an electronic file. Format information will be sent with your welcome packet, or consult with your sales representative for details.)
- Check (If funding by check, you must also complete the HSA Contribution Form F8157 which will be included in your welcome packet.)

Funds will be available in a participant's account when SelectAccount receives contribution detail information and funds are received and posted by SelectAccount. Any funds received prior to the effective date, both at the group and participant level, will not be deposited until the effective date.

Automated Clearinghouse Information for HSA Contributions

If you selected ACH for HSA Contribution amounts, please complete the section below:

I hereby authorize SelectAccount to charge our bank account through Automated Clearinghouse for **HSA contributions**. The following bank account information is provided to SelectAccount for initiation of this procedure.

Bank Name _____ Type of Account: Checking Savings

Bank Location/Branch _____

Bank ABA Number _____ Bank Account Number _____

Please include a void check.

Please note that account funding must be initiated by you through the standard electronic file format before each ACH transaction can occur.

If you wish to set up a different ACH accounts by locations, please complete the ACH Authorization Form (X9055).

VIII. CAFETERIA PLAN INFORMATION

Please indicate the plan year effective date: _____

Will the HSA interact with a Cafeteria Plan administered by SelectAccount? Yes - additional fees apply No

("Yes" should be checked if HSA is funded by employee contributions on a pre-tax basis, as indicated in section VII.)

Does this plan interact with a SelectAccount Medical FSA? Yes No

If yes, please indicate the type of Medical FSA: (select **only one**)

Post-Deductible FSA

A post-deductible FSA provides reimbursement for permitted benefits such as vision and dental care benefits until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses, excluding deductible expenses, are eligible for reimbursement.

(Choosing a Post-Deductible FSA will affect only those participants who are also enrolled in the HSA. Participants not enrolled in the HSA will have full FSA.)

Limited Purpose FSA

A limited-purpose FSA is limited to expenses for permitted benefits such as vision and dental care benefits both before and after the health plan deductible is met.

(Choosing a Limited Purpose FSA will affect everyone in the FSA, including those FSA participants who are not enrolled in the HSA.)

VIII. CAFETERIA PLAN INFORMATION (continued)

Eligibility *(It is recommended that the criteria below match that of the health plan.)*

Employees must be _____ years of age to be eligible

Employees must work at least _____ hours per week to be eligible

Waiting period *(select **only one**):* None 30 days 60 days 90 days

Benefits will begin on:

- Date of hire *(only available with "none")*
- First day after completion of the waiting period *(not available with "none")*
- First of the month after completion of the waiting period
(If waiting period ends on the first of the month, benefits begin that month.)
- Other _____

SelectAccount sends a Summary Plan Description (SPD) only if part of a cafeteria plan. The SPD will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.

If SelectAccount is administering the FSA, please submit a completed Flexible Spending Account Plan Design Guide (F9051), if not previously completed.

IX. LOCATIONS

Multiple SelectAccount locations are available for 51+ groups only. If you want multiple SelectAccount locations, please complete and attach the Location Addendum (F8928). Locations must be the same across all products administered by SelectAccount. If you wish to have different ACH accounts by location, please complete the ACH Authorization form (X9055).

X. ADDITIONAL REQUIRED INFORMATION

Agent Name *(if applicable)* _____

Agent Code _____ Agent Phone () _____

Agency Name *(if applicable)* _____

Agency Code _____ Agency Phone () _____

Internal:

Sales Representative _____ E-mail Address _____

Sales Representative Number _____ Phone () _____

Health Plan Account Coordinator _____ *(internal use only)*

SelectAccount Account Coordinator _____ *(internal use only)*

Special Instructions: _____

XI. Additional Forms

If you need additional forms or enrollment materials, please access www.SelectAccount.com or consult with your agent or sales representative.

XII. SIGNATURES

It is agreed that necessary information concerning employees or employees and their dependents participating in or subsequent to the effective date of the Plan and employees whose participation is to be changed or discontinued shall be furnished to SelectAccount on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date _____

Printed Name _____ Title _____