Allegiance℠ by Cigna Healthcare

IRC SECTION 132 (f)(4)
TRANSPORTATION REIMBURSEMENT PLAN CHECKLIST

ID#:

1. NAME OF EMPLOYER

_____
(Exactly as it is to appear with punctuation)

2. EMPLOYER'S ADDRESS

_____
(Physical)

_____
(PO Box)

_____
(City) (State) (Zip)

Telephone _____

Fax # _____

3. CONTACT PERSONNEL

Human Resources: _____

HR Phone: _____

HR E-Mail Address _____

Payroll Department: _____

PR Phone: _____

PR E-Mail Address _____

Person Authorized to amend Plan:

_____
(Name) (Title)

4. EMPLOYER'S TAX ID NUMBER

_____

5. PLAN YEAR

Begins _____
(Month / Day) (January 1)

Ends _____
(Month / Day) (December 31)

Is first year a short Plan Year?

☐ Yes, beginning _____
(Month / Day) (May 1)

☐ N/A

6. EFFECTIVE DATE(S)

Initial effective date _____
(Month / Day / Year) (1/1/2025

This restatement _____
(Month / Day / Year) (1/1/2025)

7. ELIGIBLE CLASS OF EMPLOYEES

☐ All Employees.
☐ Other: _____

8. CONDITIONS FOR ELIGIBILITY

☐ Date of Hire
☐ Other _____

9. CONTRIBUTIONS. Plan will provide for

☐ Salary reduction contributions ONLY (No Employer contribution)
☐ Employer contributions ONLY (No salary reductions)
☐ Both salary reductions AND Employer contributions
☐ After tax contributions: $_____ maximum.

10. QUALIFIED BENEFITS (May be elected for)

☐ Transportation
  ☐ Pre-Tax Contributions
  ☐ Post-Tax Contributions

☐ Parking
  ☐ Pre-Tax Contributions
  ☐ Post-Tax Contributions

11. ELECTION CHANGE FREQUENCY

☐ Quarterly
☐ Semi-Annually
☐ Annually
☐ Monthly

12. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN

☐ 60 days following each Plan Year or Termination Date.
☐ 90 days following each Plan Year or Termination Date.
☐ 120 days following each Plan Year or Termination Date.

*If you have a Flex Plan with Allegiance, your runout periods will be the same.

13. PAY CYCLE

Prior to each payroll, we plan to:

☐ Load a payroll contribution file.

☐ Auto post each pay period, Receive the payroll deduction notification seven business days prior to our scheduled payroll date. We will make any corrections needed within four business days of the notification.

Please attach a payroll calendar.

14. HOW DO YOU WANT TO FUND YOUR PLAN?

☐ Allegiance withdraws funds based on claims experience electronically by ACH.
☐ Reimbursements made directly from employer bank account.

15. OPEN ENROLLMENT OPTIONS

Online enrollment.
Enrollment through employer and send a file.

16. DELIVERY OF INDIVIDUAL ENROLLMENT CONFIRMATION LETTERS (Select method)

Mail to participants individually at $2.00 per packet.
☐ Email all enrollment confirmation letters to the employees.

17. LIST ANY ADDITIONAL COMPANIES THAT MAY BE COVERED UNDER THIS PLAN:

_____
(Company Name)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Tax ID Number)
(**NOTE:** Please attach additional affiliated Employer information)

18. LIST ANY SEPARATE DIVISIONS WITHIN THIS COMPANY:

_____
(Company Name)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Tax ID Number)
(**NOTE:** Please attach additional affiliated Employer information)

19. BROKER NAME & ADDRESS

_____
(Name)

_____
(Company)

_____
(Address)

_____
(City) (State) (Zip)

E-mail Address _____

Telephone: _____

Fax: _____

Federal Tax ID# _____

20. FEES

	FEES	
Initial Set-Up Fee	$____	
Fee for Participant/Month	$____	☐ E-Price
Minimum Monthly Fee	$____	

At the direction of the Employer named on the checklist form. It is understood that Allegiance Benefit Plan Management, Inc., is not engaged in the practice of law. Any unanswered questions may result in errors in the Plan produced by using the information from this worksheet. I understand that in preparing the requested reimbursement plan, Allegiance Benefit Plan Management, Inc., is utilizing information shown on this checklist to establish and set up the reimbursement plan you are requesting, which is not subject to ERISA. Allegiance Benefit Plan Management, Inc. makes NO REPRESENTATION OR WARRANTY OF ANY KIND, express or implied, including any warranties of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, nor is any opinion, expressed or implied, rendered by its attorneys as to the legal effect, sufficiency or tax qualification of any document utilizing Allegiance Benefit Plan Management, Inc., format. It is understood and agreed that this document should be reviewed and approved by the Employer's tax and legal counsel and that neither Allegiance Benefit Plan Management, Inc., nor its attorneys and accountants are acting as legal or tax advisors to the Employer. I hereby RELEASE, INDEMNIFY AND HOLD HARMLESS Allegiance Benefit Plan Management, Inc., its attorneys, employees, affiliates, directors and agents from any claim or liability attributable to any legal or other defect of the requested reimbursement plan.

Prepared by: _____

(Revised September 2024)

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PAYROLL DEDUCTION INFORMATION

Employer Name: _____

PAYROLL ROUNDING INFORMATION			
Rounding of Payroll Deductions: (Please indicate the rounding method for uneven deductions. Example: $1,000/elections/26 payrolls =$38.4615)	☐ Standard Rounding	☐ Adjust First Period	☐ Adjust Last Period
	☐ Round Up	☐ Adjust First Period	☐ Adjust Last Period
	☐ Round Down	☐ Adjust First Period	☐ Adjust Last Period

Payroll Name: (Example: BW or BW26)	
Benefits Deduction Payroll Cycle: (Please select your payroll cycle for withholding deductions.)	☐ Weekly (52 pay periods/year) ☐ Bi-Weekly (24 pay periods/year) ☐ Bi-Weekly (26 pay periods/year) ☐ Semi-Monthly ☐ Monthly

Please complete the specific payroll benefit deduction dates in the calendar below:

20_____		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Pay Dates	1st												
	2nd												
	3rd												
	4th												
	5th												

Payroll Name: (Example: BW or BW26)	
Benefits Deduction Payroll Cycle: (Please select your payroll cycle for withholding deductions.)	☐ Weekly (52 pay periods/year) ☐ Bi-Weekly (24 pay periods/year) ☐ Bi-Weekly (26 pay periods/year) ☐ Semi-Monthly ☐ Monthly

Please complete the specific payroll benefit deduction dates in the calendar below:

20_____		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Pay Dates	1st												
	2nd												
	3rd												
	4th												
	5th												

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DEBIT CARD IMPLEMENTATION AGREEMENT

This notice is confirmation that _____ has elected to implement the debit card option for our reimbursement accounts as of _____. As sponsor/plan administrator of the plan, we understand:

- Successful implementation and efficient administration is directly related to employer understanding and support of the process, clear and appropriate employee communications, and timely submission of plan year enrollment.
- Each participant will receive two cards; the second card may be signed and used by the spouse or dependent at the discretion of the participant.
- Plan participants will now have two reimbursement options: traditional claim filing and the debit card. IRS regulations require claims be substantiated.
- Participants will receive a cardholder agreement. Employees will certify, upon enrollment and through each use of the card, that they will use the card only for eligible expenses, that any expense paid by the card has not been reimbursed nor will the employee seek reimbursement under any other plan. Participants and their spouses will retain documentation for all expenses for submission to claims processor.
- Cards will be inactivated if a plan participant or their spouse does not provide appropriate documentation; and the participant will be required to reimburse the plan. Unsubstantiated claims not reimbursed by a participant will be charged to the employer as an expense which is offset by the gain realized when the reimbursement is removed from the plan during year-end plan reconciliation.
- Employer will have sufficient funds available at all times to cover card transactions.
- Employer will inform terminated employees that the card will be de-activated. The employer is encouraged to collect the card as part of the exit interview.

Debit Card can be used for: Medical FSA ☐ (see parameters below) Dependent Care FSA ☐

- Please review the limits of the card and choose one of the three options below. Auto-approved expenses do not require documentation to be submitted.

☐ Please use the Allegiance standard co-pays as the auto-approve standard for the debit card.

- **Options for carrier file feeds for auto-substantiation of transactions:**

☐ Medical _____
☐ Dental _____
☐ Vision _____

ALLEGIANCE STANDARD AUTO-APPROVE PARAMETER	
DESCRIPTION OF SERVICES	STANDARD CO-PAYS
Medical	$1.00 through $200.00
Prescription	$1.00 through $100.00
Dental	$1.00 through $100.00
Vision	$1.00 through $100.00

FSA Store:

TPA may receive revenue sharing fees from the FSA Store, a third party vendor, based on sales revenue from eligible products sold to Plan participants in the following amounts:

- Monthly sales revenue between $1 and $10,000 = 3% of such amount.
- Monthly sales revenue greater than $10,000 and less than or equal to $100,000 = 4% of such amount.
- Monthly sales revenue greater than $100,000 and les s than or equal to $500,000 = 5% of such amount.
- Monthly sales revenue greater than $500,000 = 6% of such amount.

SIGNED: _____ PRINTED NAME: _____

DATE: _____ TITLE: _____

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Reimbursement Accounts Employer Access Form

Plan Sponsor/Employer ___________________________________

The following individuals are authorized on behalf of the plan to request and receive from Allegiance Benefit Plan Management, Inc. subject to the limitations of applicable federal regulations, access in the below categories; protected health information (PHI) on employees and their dependents; billing information; monthly reporting; and employee adding and terminating information. Such information shall only be used for legitimate plan administration payment or health care operations purposes recognized by applicable regulations, and Plan Administrator/Employer understand that use of this information for purposes other than plan administration, payment and health care operations is strictly prohibited and that civil and criminal penalties will apply to any individual who is found to have improperly used or disclosed PHI in a manner contrary to federal regulations.

Please contact your reimbursement accounts specialist with any questions or updates for your plans account access form.

KEY*	
Automatic Reports	Any report option below will include the Account Invoice, Enrollment Verification, Year-End Report and Open Enrollment Confirmation.
Funding Reports	Includes Employer Funding and Debit Card Funding
Full Access	Manage individual employee data on employer dashboard, importing/viewing new files, view plans, request reports, view/remove reports.
Reports Only Access	Request and view/remove reports.
PHI Access	Information accessible when calling or emailing Allegiance.

Please list all persons who should have online access.

Recipient Name/Title (Please Print)	Phone Number	Email Address	Email Notification of Report Availability. **Must have either Full or Reports only Access to retrieve reports.*	Access Level:
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*

Name (Print): ________________________________ Title: ______________________

Signature: ___________________________________ Date: ______________________