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 INFORMATION

☐ New Plan
☐ Amendment and restatement

6. 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

7. EFFECTIVE DATE(S)

Initial effective date ______________________________
(Month / Day / Year) (1/1/2006)

This restatement ______________________________
(Month / Day / Year) (1/1/2006)

8. EMPLOYER ENTITY

☐ Corporation
☐ S Corporation **(2% shareholders not eligible)**
☐ Governmental Entity or Church
☐ Limited Liability Corporation
☐ Non-Profit Organization
☐ Partnership **(self-employed partners not eligible)**
☐ Sole Proprietorship **(self-employed not eligible)**

9. ELIGIBLE CLASS OF EMPLOYEES

☐ All Employees who satisfy Group Health Plan eligibility requirements
☐ 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
- ☐ Non-Resident Aliens
- ☐ Other exclusion ______________________________

10. CONDITIONS FOR ELIGIBILITY

☐ For first Plan Year only, anyone employed on the effective date of the Plan is eligible, thereafter: (Choose one from a-d below)
☐ For all years, eligibility is as follows: (Choose 1 below)

a ☐ Same as Group Health Plan eligibility waiting period
b. ☐ Date of hire (No service required)
c. ☐ ________ days after date of hire
d. ☐ ________ months after date of hire
e. ☐ ________ years after date of hire

11. ENTRY DATE

☐ First day of pay period following date requirements were met (See #15)
☐ First day of month following date requirements were met as indicated in #15
☐ Date conditions for eligibility are met (See #15)
☐ First day of Plan Year following date requirements were met as indicated in #15
☐ Same as Group Health Plan eligibility waiting period

12. CONTRIBUTIONS. Plan will provide for

☐ Salary reduction contributions ONLY (No Employer contribution)
☐ Employer contributions ONLY (No salary reductions)
☐ Both salary reductions AND Employer contributions

13. QUALIFIED BENEFITS (May be elected for)

☐ Transportation
☐ Parking

14. ELECTION CHANGE FREQUENCY

☐ Quarterly
☐ Semi-Annually
☐ Annually
☐ Other______________________________

15. WILL MORE THAN ONE COMPANY BE COVERED UNDER THIS PLAN?

☐ No or N/A
☐ Yes, include signature lines for:

____
(Company Name)
____
(Street Address)
____
(City) (State) (Zip)
____
(Tax ID Number)

16. ARE THERE SEPARATE DIVISIONS WITHIN THIS COMPANY?

☐ No or N/A
☐ Yes, include signature lines for:

____
(Company Name)
____
(Street Address)
____
(City) (State) (Zip)
____
(Tax ID Number)
(**NOTE:** Please attach additional affiliated Employer information)

17. 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.

18. PAY CYCLE

☐ Weekly (52)
☐ Bi-Weekly (26)
☐ Semi-monthly (24)
☐ Monthly (12)

Prior to each payroll, we plan to:
☐ Load a payroll contribution file. We don't need a payroll deduction notification.
☐ 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.

19. OPEN ENROLLMENT OPTIONS

☐ Online enrollment.
☐ Enrollment through employer and send a file.

20. BROKER NAME & ADDRESS

____
(Name)
____
(Company)
____
(Address)
____
(City) (State) (Zip)

E-mail Address ______________________________

Telephone: ______________________________

Fax: ______________________________

Federal Tax ID# ______________________________

21. FEES

	FEES
Initial Set-Up Fee	$_____
Fee for Participant/Month	$_____
Minimum Monthly Fee	$_____

22. DELIVERY OF INDIVIDUAL PARTICIPANT WELCOME PACKETS (Select method)

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

23. 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.

These documents are being printed by Allegiance Benefit Plan Management, Inc., at the direction of the Employer named on the checklist form, under the supervision of an attorney. 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 document requested, Allegiance Benefit Plan Management, Inc., is utilizing information shown on this checklist to produce legal documents using a format which has been designed by Allegiance Benefit Plan Management, Inc., with advice and assistance of its attorneys. Allegiance Benefit Plan Management, Inc., has made NO REPRESENTATION OR WARRANTY OF ANY KIND, expressed or implied, including no 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 the documents must be reviewed and approved by the Employer's tax and legal counsel and that neither Allegiance Benefit Plan Management, Inc., or its attorneys and accountants are acting as legal or tax advisors to the Employer. I hereby RELEASE Allegiance Benefit Plan Management, Inc., and its attorneys from any and all liability attributable to any legal or other defect in the requested documents.

Prepared by: ____

(Revised March 2020)

CORPORATE HEADQUARTERS
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Missoula, MT 59806
(406) 721-2222 or (877) 424-3570
Fax (406) 523-3149 or (877) 424-3539
www.abpmtpa.com

OREGON OFFICE
PO Box 2930
Tualatin, OR 97062
(503) 885-1888
Fax (503) 885-1988

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

This authorization allows Allegiance Benefit Plan Management, Inc. to initiate electronic withdrawal from our Employer checking account in conjunction with services provided pursuant to the Administrative Services Agreement. This authority will remain in effect until cancelled in writing or until the termination or expiration of the Administrative Services Agreement.

As an authorized representative of the Employer, I understand that Allegiance Benefit Plan Management, Inc. may initiate a reversal of any entry made under this authorization if an error has been made. I understand that the financial institution at which Employer has the above account is required to provide to designated Employer representatives the procedures for resolving errors on entries made under this authorization. I understand that Allegiance Benefit Plan Management, Inc. will provide a written notice to designated Employer representative of the error within 24 hours.

The deduction amount will be communicated to the Primary Contact designated by Employer.

PLEASE PRINT

______________________ Employer Name	______________________ Financial Institution
______________________ Primary Contact	______________________ City/State
______________________ Authorized Signature	______________________ Date
______________________ Account Number	______________________ Routing and Transit Number

Please attach a copy of a voided check to confirm banking information noted above.

Confirmed date that Claims Based Funding should start______________________

Claims payments releasing daily.

2806 Garfield, P.O. Box 4346, Missoula, MT 59806-4346
Phone: 877.424.3570 | Fax: 877.424.3539 | www.askallegiance.com

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 may need to 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 will retain documentation for all expenses for submission to claims processor.

- Cards will be inactivated if a plan participant does not provide appropriate documentation when requested 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.

SIGNED: _______________________________ PRINTED NAME: ________________________

DATE: _____________________________ TITLE: _________________________________

ALLEGIANCE ADVANTAGE

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.

Please list all persons who should have online access.

Recipient Name/Title(Please Print)	Phone Number	Email Address	Email notification for generated reports	Access Level:
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only** ☐ PHI
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only** ☐ PHI
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only** ☐ PHI
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only** ☐ PHI
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports ☐ Only**PHI
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only** ☐ PHI

**Full Access- Manage individual employee data on employer dashboard, importing/viewing new files, view plans, request reports, view/remove reports.*

***Reports Only- Request and view/remove reports.*

Name (Print): ___________________________________ Title: ________________________

Signature: _______________________________________ Date: ________________________