New Group? ☒
Current Health Group? ☐
Health Group # _____
HSA Joint? ☐

HEALTH SAVINGS ACCOUNT
Plan Checklist

ABPM Rep: ID#:

1. LEGAL NAME OF EMPLOYER

_____

EMPLOYER'S ADDRESS

_____
(Physical – address/zip code)

_____
(Billing Address)

_____.
(City) (State) (Zip)

Telephone _____

Fax # _____

2. CONTACT PERSONNEL (If more than 2, please attach)

Human Resources: _____

HR Phone: _____

HR E-Mail Address _____

Payroll Department: _____

PR Phone: _____

PR E-Mail Address _____

EMPLOYER'S TAX ID NUMBER

_____

3. DO YOU CURRENTLY HAVE A PLAN WITH ALLEGIANCE?

☐ No.
☐ Yes. Plan Type:
- ☐ Group Health Plan (If group health plan is Administered by Allegiance, claims exchange set up claims pulled to Expense Tracker).
- ☐ Health Reimbursement Arrangement (HRA)
- ☐ Health Flexible Spending Account (FSA) see below:

If Allegiance administers your current Health FSA, how would you like adjust your Plan to accommodate the HSA participant?
- ☐ HSA participants cannot have a Health FSA.
- ☐ HSA participants can participate in a limited FSA (answer below)
  - ☐ Dental, vision and qualifying OTC expenses.
  - ☐ Expenses in excess of HDHP deductible.

FOR
- ☐ All participants.
- ☐ Only HSA contributing participants.

AND, claims for medical expenses may only be submitted for
- ☐ The participant.
- ☐ The participant and all dependents.

Do you currently offer the Debit Card for your FSAs?
- ☐ Yes
- ☐ No. Would you like to offer Debit Cards for your FSAs?
  - ☐ Yes
  - ☐ No

4. EFFECTIVE DATE(S)

Initial HSA effective date _____

Allegiance effective date _____

5. EMPLOYER ENTITY

- ☐ Corporation
- ☐ S Corporation
- ☐ Governmental Entity or Church
- ☐ Limited Liability Corporation
- ☐ Non-Profit Organization
- ☐ Partnership
- ☐ Sole Proprietorship

6. CONDITIONS FOR ELIGIBILITY
- ✓ HSAs are available only to individuals with qualifying High Deductible Health Plan (HDHP) coverage.
- ✓ Not available to those receiving benefits under Medicare.
- ✓ Cannot provide first dollar coverage, with certain exceptions preventive care, dental, vision, limited-use FSA.

7. HSA CONTRIBUTIONS. Plan will provide for

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

8. EMPLOYER CONTRIBUTIONS
For each Plan Year, Employer will contribute
☐ N/A
☐ _____% of compensation per participant
☐ $_____ per participant
☐ Discretionary amount determined by Employer
*All HSA contributions must be loaded each pay period via template (provided on the Employer Portal). If there is also a Flex Plan, employee elections must be loaded on the same file.

Indicate frequency of Employer Contributions
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Quarterly

Other: _____

9. DO YOU CURRENTLY HAVE A SECTION 125 PLAN FOR PRE-TAX PAYROLL CONTRIBUTIONS?

☐ Yes (Remind your TPA to add HSA pre-tax contributions to your plan documents)
☐ No
Would you like Allegiance to set up a Section 125 Plan for your Pre-Tax payroll contributions?
- ☐ Yes
- ☐ No

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

☐ No
☐ Yes.

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

Track account separately? ☐ Yes ☐ No

Note: if separate banking is needed please include divisional banking information. HSA fee billing can be separated by division.

11. ARE THERE SEPARATE DIVISIONS WITHIN THIS COMPANY?

☐ No
☐ Yes

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

Track account separately? ☐ Yes ☐ No

(**NOTE:** Please attach additional affiliated Employer information)

If separate banking is needed please include divisional banking information. HSA fee billing can be separated by division.

12. PAY CYCLE

Please attach the payroll calendar for the plan year.

Contributions will be posted based on this calendar. *All HSA contributions must be loaded each pay period via template (provided on the Employer Portal). If employer contributions will be made, please indicate the dates on the payroll calendar. In addition, if there is also a Flex Plan, employee elections must be loaded on the same file.

13. DEBIT CARDS

All participants will receive 2 debit cards

14. BROKER NAME & ADDRESS

(Name)

(Company)

(Address)

(City) (State) (Zip)

(E-mail Address) (Telephone)

15. FEES

	FEES
Initial Set-Up Fee	
Per Participant/Month	$2.50

- ✓ **HSA Check Distribution fee $2.00** charged to participant. If they sign up for Direct Deposit this will not be charged.
- ✓ **Printed HSA Summary Fee $2.00** Printed materials are posted to the employee portal. Participants are emailed each time a statement or notification is posted if the account has a valid email address. If the participant goes on-line and elects to receive paper statements and notifications, a $2.00 fee will be charged to their account with each mailing.
- ✓ **HSA Closure fee $25.00** charged to participant.
- ✓ **Termed employee $3.95** charged to the participant. The employee is allowed to keep the account open even after termination.

16. OPEN ENROLLMENT FOR HSA PARTICIPANTS

Allegiance will provide HSA Employee Election forms for Employer payroll entry. Demographic and enrollment files will be sent to the assigned Reimbursement Account Specialist for entry into the Allegiance system.

17. Allegiance will draw funds on ACH based on the uploaded contribution file.

18. INDIVIDUAL ACCOUNT TRANSFER

☐ **This is a new HSA. No account transfer.**

☐ **The group transfer process will be used for the existing individual HSAs.**

Allegiance℠
a Cigna Company

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DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

Allegiance® a Cigna Company

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 and/or bank letter to confirm banking information noted above.

Confirmed date that Claims Based Funding should start_____

Claims payments releasing daily.

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Allegiance℠
a Cigna Company

ALLEGIANCE ADVANTAGE

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 note:

****Full Access does not include PHI (protected health information). If you would like a recipient to have full access and PHI please mark both boxes.***

****This form does overwrite your current contacts. If you do not include contacts that are already existing they will be removed from the authorized list. Please list all persons who should have online access.***

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

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

Name (Print): _____ Title: _____

Signature: _____ Date: _____