Universal Subscription Agreement (USA)
PURCHASER DETAILS

Submit this completed form with total fees due (on page 3) to TASC via one of the following methods:	Email	Fax	Mail
	newbusiness@tasconline.com	(608) 661-9638	TASC, c/o New Business Department 2302 International Lane, P.O. Box 14140 Madison, Wisconsin 53704-3140

GENERAL BUSINESS INFORMATION

Company Name:		EIN #:	
Federal Filing Status:	☐ C-Corp ☐ S-Corp ☐ Partnership ☐ Sole Proprietor ☐ Non-Profit ☐ LLC ☐ Other		
NAICS/SIC Code:			
Total # of Employees:		Total # of Benefit Eligible Employees:	
Are you a current TASC Client?	☐ Yes ☐ No	If yes, please provide your 12-digit TASC ID:	
If payroll lands on banking holidays, select one option:	☐ Apply Contributions next business day ☐ Apply contributions prior business day		
Elect TASC Card for all Accounts: Note: Card is not available for HRA plans where employee is required to meet a deductible prior to being able to submit reimbursement requests.	☐ Yes ☐ No If *No*, please explain: _____		
Include **TASC Card Decline Protection** (Max $500 for all benefits combined):	☐ Yes ☐ No Amount if other than Max: $ _____		
Class and/or Division Setup Required?	☐ Yes ☐ No **If *Yes*, complete and attach *Class & Division Designation Form (TC-6180)***		
>> If Division setup is required, will funding from different bank accounts be required?	☐ Yes ☐ No **If *Yes*, complete and attach *Bank Account Authorization & Designation Form (TC-6181)***		
EDI File:	☐ Yes ☐ No **If *Yes*, complete and attach EDI Application**		

CLIENT CONTACT INFORMATION

Client Addresses	Street	City	State	Zip
Primary/Physical Address **(no P.O. Box)**				
Billing Address				
Mailing/Shipping Address *(if different than Primary/Physical Address)*				

Authorized Contacts:

Contact Type	Contact Name	Email *(Required for Online Access)*	Phone	Identify if Primary or Secondary Contact
Client Primary Company Contact				☐ Primary ☐ Secondary
Client Billing Contact				☐ Primary ☐ Secondary
Distributor/ Broker				☐ Primary ☐ Secondary
List Additional Contacts and Contact Type *(Client, Billing, Distributor/Broker)*				
				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary

BENEFIT OFFERING SELECTIONS & FEES

Check all that apply:

UNIVERSAL BENEFIT ACCOUNT™	COMPLIANCE & CONTINUATION BENEFITS	
Benefit Accounts:	**TASC Suites:**	**Compliance Offerings:**
☐ Healthcare FSA	☐ #1: ERISA, HIPAA, FMLA	☐ ERISA Compliance
☐ Limited Purpose Health FSA	☐ #2: ERISA, HIPAA, COBRA	☐ PCORI (w/ERISA) – ***No Fee***
☐ Dependent Care Account	☐ #3: ERISA, HIPAA, COBRA, FMLA	☐ PCORI (w/o ERISA)
☐ Parking Account	☐ #4: HIPAA, COBRA	☐ Form 5500 Preparation
☐ Transit Account		☐ Non-Discrimination Testing
☐ Health Savings Account (HSA) - Full Service	**Suite Add-On Offerings:**	☐ HIPAA Compliance
☐ Health Savings Account (HSA) - Client Only	☐ ACA Employer Reporting	☐ ACA Employer Reporting
☐ Health Reimbursement Arrangement (HRA)	☐ Form 5500 Preparation	☐ Premium Only Plan (POP)
☐ Giveback Workplace Giving Account	☐ Non-Discrimination Testing	☐ Plan Only HSA
☐ EDUCATION: Student Loan Reimbursement Account		
☐ EDUCATION: Tuition Reimbursement Account		**Continuation Offerings:**
☐ Wellness Reward Account		☐ COBRA
		☐ Retiree Billing
		☐ FMLA

UNIVERSAL BENEFIT ACCOUNT: ADD-ON PACKAGES	
☐ Integration Package	☐ Priority Service Package
☐ Co-Branding Package	☐ Account Compliance Package
☐ Plan Optimization Package	☐ Other: _____

FEE SUMMARY: UNIVERSAL BENEFIT ACCOUNT

Total # of Accounts Selected Above	PPPM Fee	PEPM Fee*	Monthly Minimum Fee**	Annual Membership Fee	Fees for Add-On Packages
	Enter only one				

**If selected, Employee Census must be provided up front – and updated quarterly*
***Only applies with PPPM pricing*

FEE SUMMARY: COMPLIANCE & CONTINUATION

Selected Offerings	One Time Set-Up Fee	Administration Fee	Minimum Admin Fee	Annual Renewal Fee	Additional Services and Fees
☐ COBRA					☐ QB Takeover Fee $_____
☐ Retiree Billing					
☐ FMLA					☐ Eligibility Determination $_____
☐ ERISA					
☐ PCORI (w/out ERISA)					
☐ Medicare Part D Notice					
☐ Form 5500 Preparation					☐ Late Filing: $_____
☐ Non-Discrimination Testing					
☐ HIPAA Compliance					
☐ ACA Employer Reporting					
☐ Premium Only Plan (POP)	N/A		N/A	N/A	
☐ Plan Only HSA					
☐ **TASC SUITE # _____**					
SUITE Add-On Offerings:					
☐ ACA Employer Reporting					
☐ Form 5500 Preparation					
☐ Non-Discrimination Testing					
TOTAL FEES:					

TOTAL FEES DUE WITH APPLICATION:	

BILLING INFORMATION

Select a payment method for your fees and complete the following information for the selected payment method:

Payment Method:	ACH (E-Pay)[2]	Credit Card	Invoice	
Fees Required w/Application[1]	☐	☐	N/A	[1]*Includes, but not limited to; Universal Benefit Account Membership Fee, Set-Up Fee, HIPAA, ACA, POP, Self-Admin HRA, 5500s.*
Administration, Membership, Renewal, and Package Fees	☐	N/A	☐	
Billing Frequency:	☐ Monthly ☐ Quarterly ☐ Annually			

Banking Information:	This information will be used to process payments for services rendered		
Bank Name:		Bank Account Name:	
Bank Routing Number:		Account Number:	
Account Type:	☐ Business Checking ☐ Business Savings ☐ Personal Checking ☐ Personal Savings		

Account Funding:

If different bank accounts are required by benefit offering or by division, complete and attach *Bank Authorization & Designation Form (TC-6181)*

☐ Use same ACH information as banking information above ⇧		TASC will initiate ACH debits from the bank account and financial institution named in the amount funding section. Plan funding payments will be electronically deducted from the indicated bank account and automatically submitted on your scheduled payroll contribution dates.
☐ Use different ACH information as per below ⇩		
Bank Name:		
Bank Routing Number:		
Account Type:	☐ Business Checking ☐ Business Savings ☐ Personal Checking ☐ Personal Savings	

Credit Card Information:

Credit Card information may only be used for initial set-up fees for Offerings indicated as "Other" above.

Name on Card:			
Card Type:	☐ Visa ☐ MasterCard ☐ American Express ☐ Discover		
Card Number:		Expiration Date:	

[2]E-Pay is TASC's standard method for submission of *administration fees*. With E-Pay, TASC conveniently deducts your fees from your checking account. Simply complete the box above, signing where indicated. All written debit authorizations must agree that the Payer may revoke the authorization only by first notifying the Originator in the manner specified in the authorization. The language in the authorization represents the disclosure requirement associated with the clarification of OFAC economic sanction policies upon ACH Network Participants.

AUTHORIZATION

The data and information are being provided to implement the services purchased. This data and information is subject to the terms of the TASC Universal Subscription Agreement (USA), including TASC's reliance on its timeliness and accuracy.

Purchaser Signature: _____ Date: _____

Title: _____

TASC Admin Use Only:			
Distributor/Agent Name:		TASC Provider ID #:	
List Bill # (if applicable):		Retail Code (If applicable):	

BENEFIT ACCOUNT & OFFERING DETAILS

Complete the applicable sections below based on benefit selections from page 2.

SECTION 1: FSA Benefits *(check all that apply)*

☐ Healthcare FSA ☐ Limited Purpose Health FSA ☐ Dependent Care Account

☐ Premium Only Plan (POP) - ***complete Section 1-B only***

NEW Plan:	Plan Start Date:		Plan End Date:	
EXISTING Plan:	Plan Start Date:		Plan End Date:	
	Current Participant Count:		ERISA Plan #:	☐ Mid-Year Plan Takeover
Name of Administrator:				
If you have a current FSA, indicate who will administer the plan's Grace and Runout period(s):	☐ Prior Administrator ☐ TASC			

Plan Contributions

Healthcare FSA	Minimum (if applicable):		Maximum Contribution:	
Limited Purpose FSA	Minimum (if applicable):		Maximum Contribution:	
Dependent Care Acct.	Minimum (if applicable):		Maximum Contribution:	

Plan Details

	Healthcare FSA		Limited Purpose FSA		Dep. Care Account			
Carryover ($500 max)	☐ Yes	Amount:	☐ Yes	Amount:	N/A		N/A	
Grace Period (75-day max) *(not available with Carryover)*	☐ Yes	End Date:	☐ Yes	End Date:	☐ Yes	End Date:	☐ Yes	End Date:
Runout Period	☐ Yes	# of Days: / End Date:	☐ Yes	# of Days: / End Date:	☐ Yes	# of Days: / End Date:	☐ Yes	# of Days: / End Date:
Employer Contributions	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
If yes, enter $ amount:								
If yes, frequency of Employer Contributions will be:	☐ Same as **Employee** Contribution Schedule below ☐ Other (list below):		☐ Same as **Employee** Contribution Schedule below ☐ Other (list below):		☐ Same as **Employee** Contribution Schedule below ☐ Other (list below):		☐ Same as **Employee** Contribution Schedule below ☐ Other (list below):	

For termination of employees in Section 125 plans, select the default for eligibility end date (when employees can continue to incur expenses to):	☐ Termination Date ☐ End of the Month of Termination

	Healthcare FSA	Limited Purpose FSA	Dep. Care Account	
Runout Period for Terminated Participants	☐ End of Plan Runout ☐ _____ Days after Eligibility End Date	☐ End of Plan Runout ☐ _____ Days after Eligibility End Date	☐ End of Plan Runout ☐ _____ Days after Eligibility End Date	☐ End of Plan Runout ☐ _____ Days after Eligibility End Date

Offer Employer-Sponsored Group Health Insurance to Employees: ☐ Yes ☐ No

Benefit Plan(s) Co-pays

☐ Office Visits	List:
☐ Prescriptions	List:

Participant and Eligibility Requirements

Entry and Probationary Period: Select the employment requirement below that an eligible employee must meet at open enrollment, or at the time of hire. **If eligibility is required by class, complete *Class and Division Designation Form (TC-6180)*.**

☐ Waiting Period (enter # of Days):	
Effective Date:	☐ First of the month after waiting period ends ☐ First day after waiting period ends ☐ Same day when waiting period ends

Additional Requirements *(select all that apply)*

Included	Excluded	N/A	
☐	☐	☐	Members of bargaining units
☐	☐	☐	Part-time employees regularly scheduled to work at least _____ hours per week
☐	☐	☐	Seasonal employees regularly working at least _____ months within a year
☐	☐	☐	Employees under _____ years of age

Funding			
Number of contributions in 12-mo plan year:			
Employee Contribution Schedule:	☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly ☐ Other: _____		
Contribution Dates:	First Contribution Date	Second Contribution Date	Last Contribution Date
Point of Disbursement Funding	☐ Yes ☐ No **If *Yes*, a POD Addendum and Pre-fund is Required**		
>> If *Yes*, select frequency for funding pulls:	☐ Daily ☐ Weekly ☐ Other (List): _____		

SECTION 1-B: Premium Only Plan (POP)

Plan Start Date:		**Plan End Date:**	

Participant and Eligibility Requirements

Entry and Probationary Period: Select the employment requirement below that an eligible employee must meet at open enrollment, or at the time of hire. **If eligibility is required by class, complete *Class and Division Designation Form (TC-6180).***

☐ Waiting Period (enter # of Days):	
Effective Date:	☐ First of the month after waiting period ends ☐ First day after waiting period ends ☐ Same day when waiting period ends

Additional Requirements *(select all that apply)*

Included	Excluded	N/A	
☐	☐	☐	Members of bargaining units
☐	☐	☐	Part-time employees regularly scheduled to work at least _____ hours per week
☐	☐	☐	Seasonal employees regularly working at least _____ months within a year
☐	☐	☐	Employees under _____ years of age

SECTION 2: Commuter Benefits *(check all that apply)*

☐ Parking Account ☐ Transit Account (terminal restricted card required)

Plan Start Date:		**Plan End Date:**	
	Parking Account		**Transit Account**
Maximum Employee Contribution:			
Elect a terminal restricted card	☐ Yes ☐ No		☐ Yes – **card is required**
Allow Rollover of full available balance	☐ Yes ☐ No		☐ Yes ☐ No
Runout Period (Max 180 days)	# of Days: _____ End Date: _____		# of Days: _____ End Date: _____
Employer Contributions:	☐ Yes ☐ No		☐ Yes ☐ No
If yes, Enter $ Amount			
If yes, frequency of Employer Contributions will be:	☐ Same as Employee Contribution Schedule ☐ Other Schedule (list below):		☐ Same as Employee Contribution Schedule ☐ Other Schedule (list below):

Participant and Eligibility Requirements

Entry and Probationary Period: Select the employment requirement below that an eligible employee must meet at open enrollment, or at the time of hire. **If eligibility is required by class, complete *Class and Division Designation Form (TC-6180).***

☐ Waiting Period (enter # of Days):	
Effective Date:	☐ First day after waiting period ends ☐ First of the month after waiting period ends ☐ Same day when waiting period ends

Funding:

Number of Contributions in 12-mo plan year:			
Employee Contribution Schedule:	☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly ☐ Other: _____		
Contribution Dates:	First Contribution Date	Second Contribution Date	Last Contribution Date
Point of Disbursement Funding	☐ Yes ☐ No **If *Yes*, a POD Addendum and Prefund is Required**		
>> If *Yes*, select frequency for funding pulls:	☐ Daily ☐ Weekly ☐ Other (List): _____		

SECTION 3: HRA Benefits *(select one)*

☐ Simple HRA (First Dollar Plan) ☐ Custom HRA ☐ Self-Administration HRA ***(not available w/Universal Benefit Account)***

Effective Date:			
Plan Information			
Estimated # of New Plan Participants:		**# of Employees (FT+PT):**	
Existing HRA Plan in Place?	☐ Yes ☐ No If *Yes*, please provide the following information:		
ERISA 3-Digit Plan #:		# Current Participants:	
Name of Current Administrator:			
Runout for Terminated Participants:	☐ End of Benefit Plan Runout ☐ _____Days after Eligibility End Date		
Allow Rollover:	☐ Yes >> If elected, select one timing:	☐ After Runout End ☐ Day 1 of New Plan Year	
	☐ Available Balance (no Maximum):		
	☐ Maximum Rollover: (List)		
	☐ % of Available Balance: (List)		

Plan Start

Select and complete one of the following two options. Indicate the Plan Year dates and when TASC HRA administration begins. HRA Plan Year should match the medical plan year if applicable.

☐ New HRA Plan Year	**Plan Start Date**	**Plan End Date**	**Runout** (Max 365 days)
Plan Year:	(mo/dd/yr)	(mo/dd/yr)	_____ Days End Date _____
	Note: Plans need not run on the calendar year (i.e., January 1 – December 31)		
☐ Mid-Plan Year Takeover	**Plan Start Date**	**Plan End Date**	**Runout** (Max 365 days)
Plan Year:	(mo/dd/yr)	(mo/dd/yr)	_____ Days End Date _____
Service Start Date:	mo/dd/yr)	*Plan Sponsor must submit an aggregate balance report of participant claims paid year-to-date to adjust the participant HRA balance.*	

HRA Benefit Account Offerings

Health Insurance Carrier Name:	
Health Insurance Deductible Individual:	
Health Insurance Deductible Family:	

Participant and Eligibility Requirements

Select an Eligibility requirement below. If eligibility is required by class, complete *Class & Division Designation Form (TC-6180).*

☐ Eligibility requirements include participation in the named Health Insurance Plan; - OR –
☐ Eligibility requirements include (select all that apply below):

- ☐ Part-time employees working at least _____ hours of work per week will be included (maximum 29 hours)
- ☐ Current employees completing _____ months of service with the employer will be included (maximum 90 days)
- ☐ New employees completing _____ months of service with the employer will be included (maximum 90 days)

Benefit Account Reimbursement Options *(select all that apply)*

☐ Medical deductible	☐ Dental
☐ Prescription	☐ Vision
☐ Co-insurance	☐ Ortho
☐ Co-Pays	☐ 213(d) (all qualified uninsured medical expenses – premiums excluded)

☐ Individual Medical Premiums **(for stand-alone HRA's Only or standard HRA's Retiree Only)**

Plan Type *(select only ONE option)*

☐ Family Aggregate: Expenses can be shared by family members
☐ By Member: Embedded Deductible

TASC HRA Plan Participant and Employer Responsibility

☐ Employee Pays First (no card option)

>> If selected, enter the dollar amount employee is responsible for prior to reimbursements: $_____

Individual Maximum:	**$**				**Family Maximum:**	**$**				
HRA Reimbursement Schedule	**Percentage**		**Dollar Amount Range**						**HRA Employer Reimbursed Amount**	
		%	$		-	$			$	
		%	$		-	$			$	
		%	$		-	$			$	
		%	$		-	$			$	
	Maximum Reimbursement **per individual**:								$	
	Maximum Reimbursement **per family:**								$	

To fund your TASC HRA Plan, TASC will initiate ACH debits from the financial institution and bank account named below:	
Funding Schedule:	☐ Monthly ☐ Custom Schedule (List): _____
Funding Options:	☐ Monthly Budgeted (ACH or invoice) ☐ Point of Disbursement (ACH Only and Pre-fund Required) *>> if selected, choose frequency of funding pulls*:
	☐ Daily ☐ Weekly ☐ Other Schedule: _____

ADMIN ONLY: TASC HRA - Special Instructions:_____
Funding: _____ % (Minimum of 25%)_____

SECTION 4: HSA Benefits *(select one)*

☐ Full Health Savings Account (HSA) ☐ Client Only HSA ☐ Plan Only HSA ***(not available with Universal Benefit Account)***

Plan Start Date:		**Plan End Date:**	
Individual Contribution Limit:		**Family Contribution Limit**:	
Employee Contribution Schedule:	☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly ☐ Other: _____		
Contribution Dates:	First Contribution Date	Second Contribution Date	Last Contribution Date
Employer Contributions:	☐ Yes ☐ No **>> If *Yes*, enter $ amount:**		
If yes, frequency of Employer Contributions will be:	☐ Same as Employee Contribution Schedule ☐ Other Schedule: _____		
Contribution Amount per Coverage Level:	Single: $		
	Family: $		
Pro-rated for Mid-Year Enrollees:	☐ As of Plan Start ☐ As of Most Recent Quarter ☐ Other: _____		

SECTION 5: Giveback Workplace Giving Account

Plan Start Date:				
Benefit Account Offerings ***(select all that apply)***				
☐ Company Match	Employee Match per Employee Per Year:		Employee Match per the Employee Contribution Schedule:	
☐ Company Enrollment Bonus	Bonus Amount:			
☐ Hold a Fundraiser				

Funding			
Number of Contributions in 12-mo plan year:			
Employee Contribution Schedule:	☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly ☐ Other: _____		
Contribution Dates:	First Contribution Date	Second Contribution Date	Last Contribution Date
Employer Contributions:	☐ Yes ☐ No **>> If *Yes*, enter $ amount:**		
If yes, frequency of Employer Contributions will be:	☐ Same as Employee Contribution Schedule ☐ Other Schedule (list below):		
Funding Method:	☐ ACH Pull ☐ ACH Push ☐ Wire		

SECTION 6: Education Accounts *(check all that apply)*

☐ Tuition Reimbursement Account** ☐ Student Loan Reimbursement Account

***Tax reporting required if less than $5,250/year; work related condition education there is no limit to reimburse*

PLAN DETAILS	Tuition Reimbursement Account	Student Loan Reimbursement Account
Plan Start Date:		
Maximum Employee Contribution Amount:		
Allow Rollover:	☐ Yes >> Amount: $_____	☐ Yes >> Amount: $_____
Elect Runout Period (Max 180 days):	☐ Yes # of Days: _____ End Date: _____	☐ Yes # of Days: _____ End Date: _____
Employer Contributions:	☐ Yes ☐ No	☐ Yes ☐ No
If yes, Enter $ Amount		
If yes, frequency of Employer Contributions will be:	☐ Same as Employee Contribution Schedule ☐ Other Schedule (list below):	☐ Same as Employee Contribution Schedule ☐ Other Schedule (list below):
Runout for Terminated Participants:	☐ End of Benefit Plan Runout ☐ Days after Eligibility End Date (Enter # of Days: _____)	

Funding

Funding Type *(select one)*:	☐ Contribution	☐ Budgeted			
Number of Contributions in 12-mo plan year:					
Employee Contribution Schedule:	☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly ☐ Other: _____				
Contribution Dates:	First Contribution Date		Second Contribution Date		Last Contribution Date

SECTION 7: Wellness Reward Account

Plan Information

Describe your Wellness Plan: ***(be specific)***			
Plan Start Date:		**Plan End Date:**	
Coverage Level:		Contribution $ Amount	Definition
	Coverage Level 1:		
	Coverage Level 2		
	Coverage Level 3		
	Coverage Level 4		
Allow Rollover:	☐ No ☐ Yes **>>** Maximum Amount: $_____		
Elect Runout Period (Max 365 days):	☐ No ☐ Yes **>>** # of Days: _____ End Date: _____		
Number of Contributions in 12-mo plan year:			
Frequency of Employer Contributions:	☐ One Time with Contribution Date of: _____ ☐ Weekly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Semi-Monthly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other (explain): _____		
Employer Contribution Dates:	First Contribution Date	Second Contribution Date	Last Contribution Date
Pro-Rated for Mid-Year Enrollees?	☐ As of Plan Start Date ☐ As of Most Recent Quarter ☐ Other: _____		
Run-out for Terminated Participants:	☐ End of Benefit Plan Runout ☐ Days after Eligibility End Date (Enter # of Days: _____)		

Funding

Funding Type *(select one)*:	☐ Contribution	☐ Budgeted

CONTINUATION OFFERINGS

COBRA - Plan Details

Plan Start Date:		Purchaser Details must be received by the 15th of the month prior to this start date. COBRA Addendum is needed if requested plan start date does not meet this requirement
Number of Takeover Qualified Beneficiaries (TQBs):		Number of Employees Enrolled in Group Benefits Plan:	

COBRA Benefit Account Offerings ***(select all that apply)***

☐ Include Takeover Qualified Beneficiaries (TQBs). >> ***If selected***, please include TQB forms for each beneficiary

☐ Include Additional Subsidiaries, Affiliates, or Divisions under TASC COBRA. >> ***If selected***, complete boxes below:

NAME		SEPARATE	NAME		SEPARATE
1		☐	3		☐
2		☐	4		☐

Qualifying Events (QE)

When a COBRA Qualifying Event occurs, select when you would like the COBRA period to begin:

☐ First of the month, following the Qualifying Event ☐ Day after the Qualifying Event

☐ Other:

Additional COBRA Services ***(fees apply)***

☐ Carrier Notifications ☐ Other:

RETIREE BILLING – Plan Details

Plan Start Date:		Purchaser Details must be received by the 15th of the month prior to this start date.
Number of Participating Retirees:		

Retiree Billing Account Offerings ***(select all that apply)***

☐ Include Takeover Qualified Beneficiaries (TQBs). >> ***If selected***, please include TQB forms for each beneficiary

☐ Include Additional Subsidiaries, Affiliates, or Divisions under TASC Retiree Billing >> ***If selected***, complete boxes below:

NAME		SEPARATE	NAME		SEPARATE
1		☐	3		☐
2		☐	4		☐

Qualifying Events (QE)

When a Qualifying Event occurs, select when you would like the Retiree Billing period to begin:

☐ First of the month, following the Qualifying Event ☐ Day after the Qualifying Event

☐ Other:

Additional Retiree Billing Services ***(fees apply)***

☐ Carrier Notifications ☐ Other:

FMLA - Plan Details

Plan Start Date:		Plan must start on the 1st of the month. Purchaser Details must be received at least 5 business days before the requested start date.
Do you have employees currently on FMLA leave?		☐ Yes ☐ No >> If *Yes*, enter # of employees on FMLA leave:
Does your company policy run FMLA concurrent with worker's compensation and short-term disability plans?		☐ Yes ☐ No
Which method of reporting do you use for FMLA hours?		☐ Manual reporting via online form ☐ Data *feed (via recurring file from your timekeeping system*
Which 12-month FMLA tracking type does your company policy outline?		☐ Rolling Backward ☐ Rolling Forward ☐ Calendar Year ☐ Plan Year with Start Date of _____ / _____ / _____
Identify each State you have a location in:		
If you are subject to any State FMLA Leave Entitlement, please list the states:		
Do you have any locations that are not eligible for FMLA?		☐ Yes ☐ No

Additional FMLA Services *(fees apply)*			
☐ Eligibility and entitlement determination (free with TASC Suite)		☐ Other:	
If reporting per location is required, please enter locations and contacts below:			
Location and Contact Name		**Email Address**	
1			
2			
3			
4			

COMPLIANCE OFFERINGS

ACA EMPLOYER REPORTING Complete and submit stand-alone ACA Employer Reporting Purchaser Detail for Controlled Groups and Governmental Entities	
Plan Start Date *(must be a calendar year)*: Please indicate the calendar year in which you want reporting to start	
Health Insurance Renewal Date:	
Employer Type ***(Select One)***	
☐ Single ALE (Applicable Larger Employer (one EIN)	
☐ Aggregated ALE (more than one EIN)	
☐ Non-ALE (under 50 full-time employees	
Applicable Large Employer Status (ALE) ***(Select One)***	
☐ ALE with fully insured medical plan	
☐ ALE with self-insured medical plan	
☐ ALE with self-insured medical plan (1094B and 1095B Filing)	
☐ ALE with fully insured and self-funded plans running congruently	
Controlled Group	
Please indicate if you are a member of any of the following (required): • A Controlled Group of business entities under IRS Section 414(b) or (c); • An Affiliated Service Group under IRS Section 414(m); OR • An Arrangement Described under IRS Section 414(o)	☐ Yes *(see below)* ☐ No
Government Entity	
Are you a Government Entity that has reportable employees under more than one EIN number?	☐ Yes *(see below)* ☐ No
If you answered YES to either question above, please complete the information section below for each member entity within the Aggregated ALE, placing the entity with the most employees on top, descending to the entity with the fewest employees. A Purchaser Detail must be submitted separately for each entity.	

Entity's Legal Name	**Entity's EIN Number**

Additional ACA Reporting Services *(fees apply)*	
☐ Minimum essential coverage offer indicator	☐ Variable hour tracking

ERISA – Plan Details

Plan Start Date	The ERISA contract will be effective the first of the month in which the Purchaser Detail is received.

Plan Information ***(select all that apply; if No, leave blank)***

	Yes	No
Is Entity Part of: • A Controlled Group of Corporations under Code Section 414(b) • A group of Businesses/Trades under common control under Code Section 414(c); OR • An Affiliated Services Group under Code Section 414(m)	☐	☐
Are benefits/premiums paid from a single source? (if no, separate Purchaser Details are required)	☐	☐
Are you considered an Applicable Large Employer (ALE) under the Employer Shared Responsibility Provision of the Affordable Care Act (ACA)?	☐	☐
Do you currently track employee hours to determine if any variable hour, part-time, or season employees are full-time employees for purposes of health plan eligibility?	☐	☐
Do you offer Medical Part D Coverage? ***If Yes***, please select one of the following ☐ Credible ☐ Non-Creditable ☐ Both	☐	☐

Please complete the following information:

A	B Contract Year (mo/dd/yr)	C Benefit Contract Written to Group (G) or Individuals (I)	D Pre-Tax Benefit (Y/N)	E Insurance Carrier or Service Provider Name	F Is Benefit Self-Insured (SI) or Fully-Insured (FI)	G Total Number of Covered Participants *(not including Dependents)*
Health						
Dental						
Vision						
Life						
AD&D						
STD						
LTD						
Voluntary / Supplemental Life or AD&D						
Wellness						
Employee Assistance Program						
Stop Loss Insurance						
Voluntary Products						
Other ERISA Plans						

Additional ERISA Services ***(additional fees may apply)***

☐ Medicare Part D Notice	☐ Professional Services (billed hourly)
☐ Additional Benefit Plans (9+)	☐ Form 5500 Late Filing
☐ Carrier Certificates of Coverage Attached to Plan Document	☐ PPACA Notices
☐ Wrap Document – Individual / Separate Affiliated Employer	☐ Other:

PCORI – Plan Details

Plan Start Date		Stand-alone PCORI will start on 07/01 of the purchasing year. Please indicate the year in which you would like reporting to start.

Current Benefit Status ***(select all that apply)***

- ☐ A – Health Reimbursement Arrangement (HRA)
- ☐ B – TASC HRA Purchaser
- ☐ C – TASC Non-Excepted Health Flexible Spending Account (NEFSA) Purchaser
- ☐ D – Self-Insured Health Plan
- ☐ E – TASC Self-Administered HRA or NEFSA Purchaser

Participant Counts	
As of the first day of the FIRST month of the plan year:	
As of the first day of the FOURTH month of the plan year:	
As of the first day of the SEVENTH month of the plan year:	
As of the first day of the TENTH month of the plan year:	

INSTRUCTIONS FOR PARTICIPANT COUNT:

If you selected A only, A and E, or C and E: Participant counts should equal the number of HRA or NEFSA plan participants on the first day of each quarter of the plan year.

If you selected A and D or C and D: Participant counts should equal the total number of self-insured health plan participants on the first day of each quarter during the plan year. Count each health plan participant with self-only coverage and then add to that the number of participants with other than self-only coverage multiplied by 2.35.

If you selected D only: Participant counts should equal the total number of self-insured health plan participants on the first day of quarter of the plan year. Count each health plan participant with self-only coverage and then add to that the number of participants with other than self-only coverage multiplied by 2.35

If you selected A&B only and TASC administered your HRA in the previous year, TASC has the necessary counts. If TASC did not administer your HRA in the previous year, please provide the appropriate counts.

FORM 5500 PREPARATION – Plan Details

Plan Year Dates to be Filed:	_____ / _____ / _____ - _____ / _____ / _____
Do you have Late Filings for Form 5500?	☐ Yes ☐ No
>> If Yes, please enter the dates to be filed:	

Enter additional dates in special instructions box below

NOTE: This service offering is for ongoing 5500 plans only, not for customers who are getting 5500 preparations as part of another TASC offering. If you need a late filing only, please select under TASC ERISA service offering.

Is Entity Part of: • A Controlled Group of Corporations under Code Section 414(b) • A group of Businesses/Trades under common control under Code Section 414(c); OR • An Affiliated Services Group under Code Section 414(m) **If Benefits/Premiums are NOT paid from a single source, separate Purchaser Details are required**	☐ Yes	☐ No

NON-DISCRIMINATION TESTING – Plan Details

Controlled Group: Please indicate if you are a member of any of the following: (required) • A Controlled Group of Business Entities under IRS Section 414(b) or (c); • An Affiliated Service Group under IRS Section 414(m); OR • An Arrangement Described under IRS Section 414(o)	☐ Yes	☐ No

If you selected "Yes" in the above question, please provide a list of all other companies and incorporated business entities. Indicate on this list which entity or entities' employees participate in the cafeteria plan and indicate the type of corporation for each entity (i.e., C-Corp, Subchapter S Corp, Partnership, etc.)

NOTE: In general, all employees under a Controlled Group of employer are considered when performing Non-Discrimination Testing

Testing Options (select all that apply; fill in dates if applicable)

Yes	No				
☐	☐	Do you need testing for a Premium Only Plan – Section 125 (POP)?			
		Plan Start Date	_____ / _____ / _____	Plan End Date	_____ / _____ / _____
☐	☐	Do you need testing for a Healthcare Flexible Spending Account (FSA)?			
		Plan Start Date	_____ / _____ / _____	Plan End Date	_____ / _____ / _____
☐	☐	Do you need testing for a Dependent Care Flexible Spending Account (FSA)?			
		Plan Start Date	_____ / _____ / _____	Plan End Date	_____ / _____ / _____
☐	☐	Do you need testing for a Health Reimbursement Arrangement (HRA)?			
		Plan Start Date	_____ / _____ / _____	Plan End Date	_____ / _____ / _____
☐	☐	Do you need testing for Self-Insured Medical Plans?			
		Plan Start Date	_____ / _____ / _____	Plan End Date	_____ / _____ / _____
☐	☐	Do you need testing for Group Life Insurance?			
		Plan Start Date	_____ / _____ / _____	Plan End Date	_____ / _____ / _____

Note: Group employees of all entities must be tested if entity is a member of a controlled group of corporations, trades, or businesses under common control of an affiliated service.

SPECIAL INSTRUCTIONS *(for any offering/account)*