Employer | Set Up Application

I.F. IntegraFlex

BUSINESS INFORMATION Today's Date | Plan Effective Date | Plan Year | Tax ID No.

Legal Company Name | DBA Name

Business Type ☐ C Corp ☐ S Corp ☐ Partnership ☐ LLC ☐ LLP ☐ Sole Proprietor Other (Please Specify)

MAIN CONTACT INFORMATION

Main Contact Name | Title

Address | City | State | Zip

Phone | ext. | Fax | Email

PLAN INFORMATION

Type of Plan ☐ Premium Payment ☐ Medical Reimbursement ☐ Dependent Care Reimbursement ☐ HRA ☐ HSA

Insurance Plans to be Included ☐ Life ☐ Health ☐ Dental ☐ Vision ☐ Disability ☐ Other

Employee Eligibility Requirement First of the Month following ☐ 30 Days ☐ 60 Days ☐ Other Hours per Week Eligibility

FSA IRS Grace Period ☐ No ☐ Yes; ☐ Full IRS Allowable *(77 days)* ☐ Other *(Max up to 77 Days)*

FSA $500 Rollover ☐ No ☐ Yes Run –Off Period Employees have days to submit claims after the end of the plan year or Employee Termination date.

Pay Frequency ☐ SM *(24 PP)* ☐ BW *(26 PP)* ☐ Weekly *(52 PP)* ☐ Monthly *(12 PP)* ☐ Other

Date of First Pay Day | Flex Plan Maximum | Debit Cards ☐ Yes ☐ No

Employer FSA Contribution Amount (if applicable) per ☐ Pay Period ☐ Month ☐ Year ☐ Other

Reimbursement Methods offered ☐ Direct Deposit ☐ IntegraFlex Benefits Card ☐ Check Signature * See Enclosed Release Form ☐ Check Signature Line *Sent to Employer for Signature/Distribution

Key or Highly Compensated Employees

HRA Plan Set up Design

Please attach a copy of your HRA Plan Design.

☐ Integrated HRA ☐ Dental HRA ☐ Vision HRA ☐ Retiree HRA

Employer HRA Contribution Amount $ per ☐ PP ☐ Month ☐ Year ☐ Other

Employee Eligible to use HRA funds ☐ When Posted to account ☐ Full Annual Election as needed. ☐ Other

HRA Rollover Option ☐ No ☐ Yes; % Rollover each Year to Maximum of $

COBRA Support Services: ☐ No ☐ Yes | Number of Full-Time Employees | Part-Time Employees

Agent/Broker | Set Up Fee **Waived by TPA** | Administration Fee

Employer Signature | **Printed Name** | **Date**

Employer | Service and Facilitation Agreement

_____,
(Client Name)

is a _____ corporation for tax purposes, with
(Type of Corporation)

_____ employees. It has entered into the Agreement with
(No. of Employees)

Integrated Disability Management, Inc. DBA IntegraFlex an Idaho corporation.

The Agreement is dated ____ of _____, 20___ and sets forth an understanding between the two entities. IntegraFlex will be referred to as "TPA" and Client shall be referred to as "Client."

This Agreement is with respect to ongoing administrative services with regard to Client and their establishment of certain employee benefit arrangements (collectively referred to as the "Program"), including the following, but not limited to: Health Flexible Spending Account (FSA) and Dependent Care Account Plans under Section 125 and Section 129, respectively of the Internal Revenue Service (IRS) code, which are available as part of its cafeteria plan as well as any similar plans related to other areas of the IRS code including but not limited to Commuter Reimbursement Account Plans under Section 132, Health Reimbursement Arrangements under Section 105 and 213D, and Health Savings Accounts Plans under Section 223.

This Agreement does not change the responsibilities of Client as related to facilitation of a Section 125, Section 129, Section 132, Section 105, Section 213D or Section 223 plan.

Terms of Agreement

This Agreement is for a __12__ month term with Client responsible for the full monthly administrative fees billed each month by TPA. The Per Employee Per Month (pepm) Fee is guaranteed for the length of the term and is subject to change at the end of the Agreement term. ***This Agreement will automatically renew at the end of the Agreement term unless a 90 day advance written termination notice*** is provided by TPA or Client. In the event Client elects to terminate this Agreement the effective date of the termination will be the first day of the month following written notice of termination. All fees incurred during the time this Agreement was in effect will be due upon written request to cancel.

Business Associate

TPA is considered a "Business Associate" under HIPAA with regard to one or more employee benefit arrangements or plans offered as part of the program. To that extent, a separate agreement (refer to "Business Associate Agreement") exists between each of the employee benefit programs considered to be a "covered entity" for purposes of HIPAA and TPA (as Business Associate) to document compliance with HIPAA's privacy, security, and electronic data interchange (EDI) requirements.

Understanding

Client is the Plan Administrator for their Section 125, Section 129, Section 132, Section 105, Section 213D and Section 223 (if applicable) plans. TPA is contracted to assist Client to fulfill their responsibilities as Plan Administrator by supplying the services listed within this Agreement. Client acknowledges that TPA has no discretionary authority or control with respect to management or administration of the plans, dispensation of assets/funds, and investment of funds remitted to TPA and the client is acting solely at its discretion.

As a Business Associate for Client, TPA will accept direction from Client regarding reception of payments from Client and processing payments under the corresponding program(s) offered by Client. ***TPA shall only be responsible for processing requests for reimbursement to the extent Client has deposited sufficient funds in its own bank account to cover reimbursement to the employee or member. TPA does not operate a trust account and TPA will not be expected to extend its own funds in the payment of Flexible Spending, Dependent Care, Commuter Reimbursement, Health Reimbursement, Health Savings or any other plan reimbursements.***

Facilitation Services Provided by TPA to Client

In general, TPA is providing a variety of administrative services related to the program, including reimbursement and recordkeeping services with regard to Client's Health Flexible Spending and Dependent Care accounts. When applicable to its Commuter Reimbursement, Health Reimbursement and Health Savings account plans.

- *Customer Service Support*. TPA provides customer service support by telephone during normal Mountain Standard business time hours and electronic administrative services 24 hours per day, 7 days per week (I.e. IntegraFlex Online Participant Portal and IntegraFlex Mobile Application).
- *Claims Determination and Reimbursements*. TPA makes the initial determination as to whether participants are entitled to reimbursement for a claim submitted under Client's program. Benefits payments must be made within the timeframes specified in plan documentation.

To the extent a submitted claim is not paid in full, TPA is required to provide a denial notice in accordance with the terms and conditions specified in the plan document. Appeals of denied claims are decided by Client.

- *Eligibility/Enrollment Data*. Client performs enrollment and determines eligibility to participate in the benefit program. Client performs the enrollment function on behalf of the programs' participants and beneficiaries, not on behalf of the program. In particular, the Health FSA's enrollment information created by Client is employer information and is not PHI. TPA receives plan enrollment (I.e. electronic media or paper enrollment) and eligibility data from Client and prepares Eligibility Reports for the client to review. Upon receipt by TPA, enrollment information for the Health FSA becomes PHI and, therefore, is subject to the HIPAA privacy rule; if such PHI is transmitted by or maintained in electronic media, it becomes electronic PHI (ePHI), also subject to the HIPAA security rule.
- *Forms and Plan Document Responsibilities*. TPA will provide Plan Documents, including a Summary Plan Description (SPD), for review by Client and/or their legal counsel for prior adoption by Client. Client and/or their legal counsel are solely responsible for review and revision prior to signing and implementation. TPA will provide, but not limited to: all enrollment, termination and claim forms (I.e. electronic and paper format) for use in day to day plan administration by Client and its employee participants.

  Note: Client and not TPA, is ultimately responsible for the accuracy and completeness of their SPD and other plan related documents.
- *Plan Reports.* Client receives an electronic reporting via email at least once monthly reflecting participant claim information. Participants receive an electronic reporting via email at least once monthly, an account statement reflecting individual account balance, contributed YTD and reimbursed YTD amounts.
- *Form 5500.* TPA will provide the data necessary to Client for its own preparation of its Form 5500 for their Health FSA, if a Form 5500 is required, but TPA will not prepare the Form 5500 for Client.

  Note: An ERISA Form 5500 should not be required for a Health FSA, when the plan has fewer than 100 participants and payments are to be made from Client's general assets, it should quality for a filing exemption). Client is strongly urged to engage its own legal, tax or other related advisor regarding.
- *Gramm-Leach-Bliley Act Responsibilities.* TPA is responsible for providing any necessary notices to Client with regard to personal financial information and medical records under the Gramm-Leach-Bliley Act and any applicable state law.
- *Subcontractors.* This agreement permits TPA to use subcontractors and makes TPA responsible for the performance (or non-performance) of a subcontractor.
- *Participant Education.* TPA will provide information to employee participants as to how each plan operates their rights and responsibilities. TPA offers to hold informational seminars for in-person description of benefits, services and methods for reimbursement ***when requested by client***.

  Note: TPA reserves the right to bill for any lodging/travel expenses incurred by TPA to Client for in-person onsite seminars.
- *Enrollment Confirmation.* TPA will deliver electronic confirmation to each employee electing to enroll in one or more of the plans.
- *Reimbursement Submission Requests.* TPA will facilitate reimbursement requests subject to the regulations of the IRS and/or Client's direction. TPA will offer a variety of reimbursement submission request mechanisms for reimbursement of qualified expenses, including but not limited to: conventional mail or fax forms, physical address for in-person delivery and a 24 hours per day, 7 days per week web engine for electronic (I.e. IntegraFlex Online Participant Portal or IntegraFlex Mobile Application) submission with paper substantiation.
- *Reimbursement Payment Methods.* TPA will offer a variety of reimbursement payment method mechanisms for reimbursement of qualified expenses, including but not limited to: IntegraFlex debit card, direct deposit, manual paper check and check export electronic file.
- *Reimbursement Frequency.* IntegraFlex debit card reimbursements ***must be daily***. All other reimbursement (I.e. direct deposit, manual paper check, check export electronic file) frequencies (I.e. daily, weekly, bi-weekly) can be set by Client's direction.

Employer | Service and Facilitation Agreement

Responsibilities of the Client

- *Fiduciary Responsibilities.* Client is the Plan Administrator for purposes of ERISA. TPA only agrees to perform non-discretionary, ministerial duties and purports not to be the Plan Administrator or a fiduciary of the Health FSA or any other benefit plans. However, as noted above, TPA may be a functional fiduciary to the extent its authority or conduct meets the definition of a plan fiduciary under ERISA.
- *Changes in Election.* Client is responsible for making all election change determinations under the plans. Updated eligibility data, reflecting election changes and family status changes, must be provided to TPA within **48 hours of the change event** or as soon as reasonably possible.
- *COBRA and HIPAA Compliance.* Client is responsible for compliance with COBRA and HIPAA (portability, privacy and security), including issuing all required notices and certificates, although, as a business associate, TPA must comply with HIPAA's privacy and security requirements.

  Note: Client can choose to engage TPA to administer its COBRA responsibility under a separate COBRA Service Agreement between Client and TPA.
- *Non-Discrimination Testing.* Employee benefit plan compliance is the ultimate responsibility of Client. Neither TPA nor its employees can or do take an ultimate position on plan discrimination. Any information provided to Client, documents and reports, are provided as general information only and does not constitute legal, accounting or any other form of professional advice from TPA. Client is strongly urged to engage its own legal, tax or other related advisor to review the information provided herein. TPA takes no responsibility for any incorrect information provided to it by Client or its Agent. Furthermore, Client is also advised that any information provided by TPA constitutes a "snapshot" of Client's program during a moment in time and that discrimination results can change over the course of a program's plan year as participants, participation elections or other aspects of the program(s) change.
- *Gramm-Leach-Bliley Act Responsibilities.* Client is responsible for any necessary notices that may be required by law to be provided to participants with regard to the use of personal financial records or medical records under the Gramm-Leach-Bliley Act and any applicable state law.
- *Funding Benefits.* Client is responsible for making funds available to pay benefits under the programs. TPA is not required to, and will not, use its own funds and then seek payment from Client.
- *Method of Funding.* Client authorizes (refer to "Debit Card/Direct Deposit/Check Printing Request Authorization Form") TPA to pay benefits under the program by IntegraFlex debit card, direct deposit and/or manual paper checks written on a general assets bank account established and owned by Client. TPA electronically notifies via email, Client of the amount necessary to pay claims on a daily (I.e. necessary with IntegraFlex debit card), weekly, bi-weekly or other schedule set by Client's direction. Client will ensure funds are available for disbursement from their general assets bank account provided to TPA to work from for claim reimbursements to participants.
- *Document/Form Responsibilities.* Client will distribute the necessary forms and all other applicable documents provided by TPA or the IRS to its participants.
- *Participant Contributions.* Client is responsible for payroll amounts direct to each program or TPA based on reports available from TPA.
- *Reporting to TPA.* Client will provide in a timely manner, to TPA, such items as employee census, payroll data and other reasonable and necessary information required to service the program(s).

Employer | Service and Facilitation Agreement

Indemnification

TPA indemnifies and holds harmless Client from any and all losses and liabilities resulting from any breach of TPA's responsibilities and duties provided under this agreement.

Client indemnifies and holds harmless TPA from any and all losses and liabilities resulting from the Client's breach of responsibilities and duties provided under this agreement and Section 125, Section 129, Section 132, Section 105, 213D and Sections 223 of the IRS Code.

All reimbursement requests submitted to TPA are assumed to be authorized by Client and Client agrees to indemnify TPA against any and all losses and liabilities resulting from payment of claims processed as provided for in this agreement.

Fees and Payment

Around the 5th of each month TPA will submit a statement to Client showing TPA fees for service during the previous month. Client agrees to pay such fees through ACH Debit on the 10th of each month or the next available business day following the 10th. Client hereby authorizes (refer to "ACH Debit Authorization Form") and requests TPA to effect payment for any amounts owing by Client to TPA as such amounts become due by initiating debit entries to Client's bank account as identified.

The below listed fee schedule will apply for the benefit plan:

This benefit plan will start on _____

One Time Set Up Fee	$ **Waived by TPA**
Annual Renewal Fee	$ **250.00**
Per Employee per Month (pepm)	$ _____
Monthly Minimum	$ **60.00 per month**

Amendment

Neither Client nor TPA can assign this Agreement without the other party's written consent, in which consent will not be unreasonably withheld. This Agreement may be amended only by written agreement of duly authorized officers of Client and TPA.

Complete Agreement

This Agreement (including any Appendices) is the full Agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements and representations between the parties, other than the separate applicable Business Associate Agreement between any Program, subject to the HIPAA privacy rule and TPA. This Agreement shall be construed, enforced and governed by the laws of the State of Idaho.

IN WITNESS WHEREOF, Client and TPA have caused this Agreement to be executed in their names by their undersigned officers, the same being duly authorized to do so.

INTEGRAFLEX

Keith S. Paduch
By

CEO
Its

_____
Signature

_____
Date

CLIENT

_____
By

_____
Its

_____
Signature

_____
Date

Employer | Debit Card/Direct Deposit/Check Printing Request Authorization Form

I.F. IntegraFlex

BUSINESS/GROUP INFORMATION

We, the below listed Employer Group, are requesting and authorizing IntegraFlex (MBI Settlement) to ACH draft for Debit Card/Direct Deposit claims and print checks (if applicable) related to manual reimbursements against our FSA or HRA on our bank account. Checks will then be forwarded to our group (in bulk) for signature and distribution or if we provide signature (Check Signature Release Form), IntegraFlex will distrubute to each individual participant.

Note: Please be advised that a $1.00 prenote test will be preformed by the Debit Card/Direct Deposit Vendor ***(MBI Settlement)*** to ensure that your account is active and operational. They do not return the $1.00 transaction to your account _____ Initials

Group Name

Business Name Associated with this Account

Address of Business | City | State | Zip

Return Address | City | State | Zip

ACCOUNT/BANK INFORMATION

Routing Number | Beginning Check Number

Account Number | ABA Routing Number*

Bank Name

Bank Address | City | State | Zip

Is this a Sub Account of another Account? ☐ Yes ☐ No

Account type ☐ Checking ☐ Savings ☐ Money Market

Tax ID Number Associated with this Account

*This is Not the same as the routing number. *92-372/1234 3655 (for example)*. Some banks still use this number. Please check with your Individual Banking Institution to see if they utilize the ABA. Contact IntegraFlex if you have questions on this at 208.287.0310

Authorized Person Name

Signature | **Date**

Employer | Check Signature Release Form

EMPLOYER CHECK SIGNATURE RELEASE

I am submitting my signature as an authorized Signer on the supplied Banking account and I understand my signature will be used as the Signature of Record on all employee reimbursement checks sent out to employees by IntegraFlex.

Printed Name _____

First Signature _____

Second Signature
(If Dual Signatures Required) _____

2402 W. Jefferson Street | Boise, Idaho 83702 | t. 208.287.0310 | f. 208.287.0311 | integra-flex.com

Employer | ACH Debit Authorization Form

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Company Name: INTEGRATED DISABILITY MANAGEMENT

Company ID Number: 1-260404651

I (we) hereby authorize Integrated Disability Management, Inc. d/b/a/ IntegraFlex hereinafter called COMPANY, to initiate debit entries to my (our) *(select one)*

☐ **Checking Account**

☐ **Savings Account**

indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY INFORMATION

Depository Name | Branch

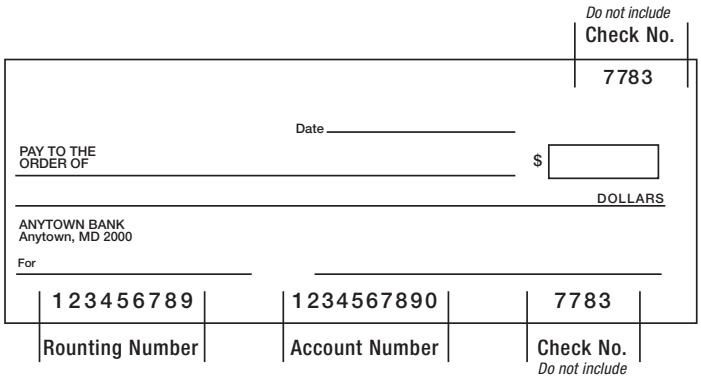
Address | City | State | Zip

Routing Number *(9 Digits)* | Account Number

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s) *(Please Print)*

Signature **Date**



Please attach a **VOIDED CHECK** to this authorization if a checking account will be debited.
The routing and account numbers may be in different places on your check.