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

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?

☐ Yes. Plan Type: ______________
☐ 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

9. BENEFIT LIMITATIONS

Year	Single Contribution Limit	Family Contribution Limit	55+ Contribution Limit
2016	$3,350.00	$6,750.00	$1,000.00
2017	$3,400.00	$6,750.00	$1,000.00

10. OPEN ENROLLMENT OPTIONS

☐ Online enrollment for HSA elections & agreements (employee HSA contributions will be handled by the employer) need demographic file
☐ Employer will upload demographics and HSA elections (employee HSA contributions will be handled by the employee) *if group has health with Allegiance note to add claims exchange flag.
☐ Send an electronic HSA Employee Election form for the Employer to use for Employee elections and entry for payroll

11. 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.

12. 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.

13. PAY CYCLE

☐ Please attach the payroll calendar for the plan year, this is needed each year.

Prior to each payroll, we plan to:
☐ Upload Employer/ Employee HSA contributions each pay period.

14. DEBIT CARDS

☐ Yes all participants will receive 2 debit cards

☐ If group health plan is Administered by Allegiance, claims exchange set up claims pulled to Expense Tracker.

15. BROKER NAME & ADDRESS

____
(Name)
____
(Company)
____
(Address)
____
(City) (State) (Zip)
____
(E-mail Address) (Telephone)

16. FEES

	FEES
Initial Set-Up Fee	______
Per Participant/Month	______

HSA Check Distribution fee ______
Charged to participant. If they sign up for Direct Deposit this will not be charged.

Printed HSA Summary Fee ______
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.

HSA Closure fee ______
Charged to participant.

Termed employee ______
Charged to the participant. The employee is allowed to keep the account open even after termination.

17. HOW DO YOU WANT TO FUND YOUR PLAN?
For each Plan Year, Employer will contribute

☐ Healthcare Bank withdraws funds based on total contribution file posted electronically by ACH.

18. REPORT RECIPIENTS (list below for each report):

Employer Summary Report Notification (monthly): ______
Account Detail Report Notification (monthly): ______
Fee Funding Notification (monthly): ______
Employer Funding Notification (payroll): ______
Funding Collection Notification (payroll): ______

CORPORATE HEADQUARTERS
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Fax (503) 885-1988

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

Allegiance® a Cigna Company

Please complete the following form and return with one of the following documents:

- Voided Check **OR**

- Letter from your bank with your account and routing number listed as well as contact information for the representative at the bank.

I have attached either a voided check or a letter from our bank that states our account number, routing number and bank contact.

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

On behalf of ________________________________, I understand that Allegiance Benefit Plan Management, Inc. may initiate a reversal of any entry made under this agreement if an error has been made. I understand that the financial institution at which I have the above account is required to provide me the procedures for resolving errors on entries made under this agreement. I understand that Allegiance Benefit Plan Management, Inc. will provide a written notice to me of the error within 24 hours.

The deduction amount will be communicated to the Primary Contact.

PRIMARY CONTACT:	AUTHORIZED SIGNER:
EMAIL ADDRESS:	AUTHORIZED SIGNATURE:
PHONE NUMBER:	DATE:

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