



HEALTH SAVINGS ACCOUNT (HSA) DIRECT PLAN DESIGN GUIDE

Please complete this form and return to Further 30 days before your effective date so we can properly administer your plan.

If you have any questions, please call our Sales Line at 855-363-2583. When complete, email this form to

Further.Sales.Support@HelloFurther.com; fax it to 1-866-231-0214; or mail it to Further, PO Box 982814, El Paso, TX 79998-2814.

All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Legal Business Name _____

Employer's Street Address _____

City _____ State _____ ZIP Code _____

Employer's Tax I.D. Number (required) _____

Type of Corporation S Corporation* C Corporation Partnership* Sole Proprietor*
 Political Subdivision/Church LLC* Non-Profit Other _____

*2% or more shareholders of an S Corporation, along with partners in a partnership, sole proprietors and members of an LLC or PLLP do not have access to an FSA.

Number of Employees Eligible for Plan: _____

Primary Contact Person:

(Has access to all plan information and can add, edit, or remove portal access for additional contacts)

Primary Contact Person _____ Title _____

Phone Number () _____

Email Address _____

Additional Contact Person:

(Has access to all plan information and edit access for group portal)

Additional Contact Person _____ Title _____

Phone Number () _____

Email Address _____

Additional Contact Email Notifications

Fee Billing

II. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Carrier _____ Effective Date _____

III. AGENCY/BROKERAGE INFORMATION

Agency Name: _____ Agency Code: _____

Agent Name: _____ Agent Code: _____

Agency Contact Name (if different than agent): _____

Email: _____ Phone: _____

Address: _____

IV. ACCOUNT ADMINISTRATIVE INFORMATION

Further offers three different options for HSA Accounts. *(The fees for each option are listed on the pricing sheet.)*

Please select one HSA plan option:

Further Premium HSA Further Value HSA Further Select HSA

(Members can choose a different plan option and they will be billed the difference out of their HSA account directly)

Plan Year

Start date _____ End date _____

Cafeteria Plan Information

Do you allow pre-tax contributions?

Yes No

If yes,

I will need a cafeteria plan set up with Further.

I will already have a cafeteria plan in place with another vendor when the account is effective.

I do not need Further to setup a plan.

Eligibility *(generally matches that of the health plan)*

Employees must work at least _____ hours per week to be eligible

Benefits will begin on: (select **only** one):

First of the month following date of hire

Date of hire

First of the *month* after completion of the waiting period 30 days 60 days 90 days Other _____

Employer Contributions: Will the employer contribute to the accounts? Yes No

V. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another administrator? Yes No

If yes, participants who wish to transfer dollars are required to complete the Transfer Request Form (F7320) after the account is established.

VI. ADMINISTRATIVE FEES

Fees will be billed on a monthly basis. If participant paid, the monthly fee will be taken from the participant's account balance

Participant Fees

Employer Paid Participant Paid

You will receive an email when your detailed billing information is available and another e-mail notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign into the Online Group Service Center to view and print your invoice detail under Reports and Invoices.

Automated Clearinghouse Information

I hereby authorize Further to charge our bank account through Automated Clearinghouse for Administrative Fees. The following bank account information is provided to Further for initiation of this procedure.

Bank Name _____ Type of Account: Checking Savings

Bank ABA Number _____
(The ABA number is the nine-digit number located in the lower left corner of your check.)

Bank Account Number _____
(Funds will be drawn from your bank account on or after the 20th of each month.)

VII. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

- Employer will enroll participants online using the Online Group Service Center at **hellofurther.com**
- Participants will enroll online at **hellofurther.com**
- Employer will enroll participants using a secure file transfer process

VIII. DEDUCTION/CONTRIBUTION INFORMATION

Select one of the following deduction/contribution methods:

1. **Direct Deposit/ACH Push:** An ACH push is a customer or member initiated transaction of an electronic transfer of funds. An account number report will be available in the online group service center once the enrollment is completed.
2. **Online Group Service Center:** Upload your payroll deduction information here.
3. **Secure File Transfer with ACH pull:** This option allows employers or their vendors to create a file using Further format requirements via automated secure upload.

Account funding must be initiated by you through the standard electronic file format before each ACH transaction can occur. (Required if electronic file is selected)

If you selected option 2 or 3, complete the banking information below:

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **HSA contributions**. The following bank account information is provided to Further for initiation of this procedure.

Use same answer as above

Bank Name _____ Type of Account: Checking Savings

Bank ABA Number _____

(The ABA number is the nine-digit number located in the lower left corner of your check.)

Bank Account Number _____

IX. ADMINISTRATIVE TIPS

ONLINE ACCESS: hellofurther.com

With Further, your employees have access to a powerful tool for managing their HSA. By registering with hellofurther.com, your employees can:

- Open an HSA
- Make withdrawals from their account
- Enroll in direct deposit
- Make online contributions
- View recent claims or reimbursement requests
- Create and view a customized statement
- Manage their personal profile
- Request a debit card for a dependent(s)

You can also access forms and enrollment materials at **hellofurther.com**.

LOCATIONS: Multiple Further locations are available for 51+ groups only. If you want multiple Further locations, please complete and attach the Location Addendum (F8928). Locations must be the same across all products administered by Further. If you wish to have different ACH accounts by location, please complete the Group ACH Authorization Agreement Form (X9055).

COORDINATING WITH AN FSA: For participants that have a FSA and a HSA, the FSA provides reimbursement for permitted benefits such as vision and dental care benefits until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses, excluding deductible expenses, are eligible for reimbursement.

This affects only those participants who are eligible to contribute to their HSA. Participants who are not eligible to contribute to an HSA will have a general purpose (Full) FSA.

Please note: If the HSA is not administered by Further or the health plan is not with Blue Cross and Blue Shield of Minnesota, the group is required to manually notify Further which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (F8978) to Further to indicate that the deductible has been satisfied prior to receiving reimbursement for 213(d) eligible expenses.

PLAN DOCUMENTS: Further sends a Summary Plan Description (SPD) only if part of a cafeteria plan. The documents will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.

X. SIGNATURES

It is agreed that necessary information concerning current and future employees and/or their dependents who participate in this Plan, and employees whose participation is to be changed or discontinued, shall be provided to Further on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date _____

Printed Name _____ Title _____

XI. For Office Use Only:

Distribution/Channel Partner _____

Market Segment _____