FURTHER℠

Formerly SelectAccount®

PREMIUM ONLY PLAN PLAN DESIGN GUIDE

Please complete this form and return to Further before your effective date.
If you have any questions, please call our Sales Line at 855-363-2583. When complete, fax this form to 1-866-231-0214; mail it to Further, PO Box 64193, St. Paul, MN 55164; or email it to Further.Group.Administration@hellofurther.com.

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

I. EMPLOYER INFORMATION

Employer's 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: _____

Person Responsible For Authorization of Plan Design:
(Responsible for signing the Plan Design Guide and approving the plan design)

Name _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address _____

Main Contact Person:
(Has access to all plan information when calling Further and will automatically be granted full access to the Online Group Service Center)

Main Contact Person _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address_____

Additional Contact Person:
(Has access to the plan information indicated below when calling Further. Access to the Online Group Service Center may be granted by the Main Contact who will decide what online access is assigned by logging into the Online Group Service Center)

Additional Contact Person _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address_____

Additional Contact Person has access to when contacting Further:

☐ All plan information OR ☐ Fee billing information ☐ Claim billing information

* Log into the Online Group Service Center to grant access to additional users or to add contacts.

II. AGENCY/BROKERAGE INFORMATION

Agent/Broker Name *(if applicable)* _____ Email Address _____

Agent/Broker Code _____ Agent/Broker Phone _____

Agency/Brokerage Name *(if applicable)* _____ Email Address _____

Agency/Brokerage Code _____ Agency/Brokerage Phone _____

Agency/Brokerage Tax ID _____-_____

Agency/Brokerage Address _____

III. PLAN INFORMATION

Plan Year

Start date _____ End date _____

Health Plan Carrier _____

Plan Options

☐ Premium Only Plan (POP) - employer sponsored health plan.

Eligibility - Required for Plan documents (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 *day* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

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

IV. ADMINISTRATIVE FEES

You will receive an automated e-mail notification 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 complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **Administrative Fees for an annual fee.** 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 or savings deposit slip)

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

IX. ADMINISTRATIVE TIPS:

PLAN DOCUMENTS: Further will be preparing your Plan Document and Summary Plan Description (SPD). 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 _____

XV. For Office Use Only:

Further Group Number _____ Sales Exec _____

Market Segment _____ Further Account Manager _____

Health Plan Account Manager _____ Client Manager_____

Distribution Partner _____ Enrollment Specialist _____

Distribution Partner Account Manager _____