

Please complete this form and return to Further 45 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, 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 _____

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 Group Online 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. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another VEBA Trust? Yes No

If yes, indicate the date the Trust was established _____

Please provide us with the contact information for the prior administrator and Trust:

Administrator Name _____

Phone Number _____ Email Address _____

Trust Name _____

Phone Number _____ Email Address _____

IV. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health plan carrier _____

V. VEBA ADMINISTRATIVE INFORMATION

Please indicate the account effective date _____

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

Plan Features

Select one or more of the following features:

- Post-retirement Health Care Savings Arrangement (amounts payable after employee's retirement from public employment). If this feature is chosen, select all that apply below:
 - Accounts funded with accrued severance pay, vacation pay, sick pay or similar amounts following termination of employment
 - And/or
 - Accounts funded over employee's working life for use in retirement
- Health Reimbursement Arrangement for Active Employees

VI. ADMINISTRATIVE FEES

For participants who have a VEBA stacked with a second Further product like an FSA or HRA, only the highest fee will apply. The lower participant fee will be waived.

Participant Fees for employees:

- Employer Paid *(If your group offers another medical account with Further, the fees must be paid on a monthly basis.)*
Indicate billing frequency: monthly annually
- Participant Paid *(Billed monthly and taken from participant's account balance.)*

Please indicate the contact person for administrative fees, if different from main contact person:

Name _____ Title _____

Phone Number () _____ Email Address _____

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 in to the Online Group Service Center to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information (completion of this section is mandatory)

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 or savings deposit slip)

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:

- Electronic File
- Group Online Service Center. Employer will enroll participants online using the Group Online Service Center at **hellofurther.com**

(Electronic enrollment file format requirements will be provided via email following the approval of the plan design guide.)

VIII. CONTRIBUTION INFORMATION

It is required that you submit contribution information via an electronic file. Format information will be sent with your welcome email.

Automated Clearinghouse Information for VEBA Contributions

Please note that account funding must be initiated by you through the standard electronic file format before each ACH transaction can occur.

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **VEBA contributions**. 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 _____

IX. REIMBURSEMENT

Reimbursement

- Employees use the debit card to pay for expenses just as they would use a bank debit card. All participants will be issued one debit card. A debit card for dependents) may be requested online.

Copay Amounts

The copay amounts provided below will allow these members to auto substantiate when the debit card is used. Documentation will not be required for reimbursement.

Please indicate the health plan copay amounts below or attach a separate spreadsheet indicating the copay amounts:

Medical: _____ Vision: _____ Drug: _____

X. ADMINISTRATIVE TIPS

ONLINE ACCESS: hellofurther.com

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

- Enroll in direct deposit
- Create and view a customized statement
- View recent claims or reimbursement requests
- Manage their personal profile

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 Form (X9055).

COORDINATING WITH AN HSA: For participants that have a VEBA and a HSA, the VEBA 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 full VEBA.

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.

PRIMACY INFORMATION: If you are also offering an FSA administered by Further, eligible expenses will be reimbursed from the Medical FSA until a participant's account is exhausted. Only then will eligible expenses be reimbursed from the participant's VEBA Account for Active Employees.

XI. 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 _____

XII. 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 _____	