Employer FSA Setup Form

I. Employer Information

Legal Name / Plan Sponsor: _____

Business Address: _____

Federal Tax ID: _____ Number of Eligible Employees: _____

Contact: _____ Title: _____

Email: _____ Phone: _____

II. Prior FSA Information

Existing Medical FSA? ○ Y $ _____ ($2,850 max) ○ N

Existing Dependent Care FSA? ○ Y $ _____ ($5,000 max) ○ N

Rollover Avail. for an Existing FSA? ○ Y $ _____ ($570 max) ○ N

Administrator for Current Run Out: ○ Current Administrator: _____ ○ GBS

Comments: _____

III. FSA Options Offered

Medical FSA? ○ Y $ _____ ($2,850 max) ○ N

Dep. Care FSA? ○ Y $ _____ ($5,000 max) ○ N

Plan Year Eff. Date: _____

Plan Year End Date: _____

Run Out Period*: ○ 90 Days (standard) ○ Other: _____

Note: *You can select a grace period (2.5 months) or a rollover ($570 max), but not both.*

○ Grace Period? *-or-* ○ Rollover? $ _____ ($570 max) *-or-* ⊙ Neither

Comments: _____

**Run Out Period is the period following the end of a Plan Year in which participants may continue to submit expenses incurred during the Plan Year.*

IV. FSA Funding / Reporting

Funding Frequency: ○ Monthly ○ Bi-Weekly ○ Other: _____

Funding Method: ○ Check ○ ACH (ACH Form req'd)

Reporting* Sent: ○ with Funding ○ by Email

Comments: _____

**Reporting is required in order to post contributions correctly.*

V. Payroll / Employee Contribution Schedule

Payroll Frequency: ☐ Monthly(12) ☐ Bi-Monthly(24) ☐ Bi-Weekly(26) ☐ Quad-Monthly(48) ☐ Weekly(52)

Number of FSA Contribution Withholdings:_____

Annual Election is Calculated From: ○ Contribution *"x"* # of Payroll Withholdings ○ Annual Election*

If contributions don't follow a payroll schedule, describe how you plan to fund the contributions below.
Comments:_____

**If per pay period contributions "x" # of withholdings don't equal annual contributions, the employer is req'd to make adjustments.*

VI. Employee Termination

Employee Account Termination: ○ Date of Termination (standard) ○ Last Day of the Month

Comments:_____

VII. FSA Fund Access

Offer Debit Card? ○ Y ○ N

Offer EFT Deposits?* ○ Y ○ N

Comments:_____

**See the EFT form for details.*

VIII. Employer Review and Sign-Off

By signing below, the client confirms they have reviewed this document in its entirety and warrants that it accurately reflects the accounts and services that said party has requested GBS administer on behalf of their organization(s).

Authorization

Printed Name: _____ Title:_____

Group Signature:_____ Date: _____