FURTHER℠
by HealthEquity

THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

FLEXIBLE SPENDING ACCOUNT (FSA) EMPLOYER ENROLLMENT FORM

The Further Healthcare FSA plan is offered through the Board of Pensions to employers whose employees are eligible for the Benefits Plan of the Presbyterian Church (U.S.A.) PPO or EPO medical options or other group health coverage. Employers offering the Benefits Plan high deductible health plan (HDHP) option are limited to the Further Health Savings Account (HSA) benefits, which requires a different form. Dependent Care FSA is not limited by Medical Plan eligibility. Further is solely responsible for all administrative and financial operations of the FSA.

Please complete this form and return to Further no later than 45 days before your effective date in order to properly administer your plan. All fields are required; incomplete forms will cause delays setting up your plan.

If you have any questions filling out this document, please call our Employer Service Line toll free at: 888-460-4013 from 8 a.m. to 5 p.m. CT, Monday through Friday. When complete, email this form to Further.Sales.Support@hellofurther.com or mail it to Further, PO Box 14836, Lexington, KY 40511.

I. EMPLOYER INFORMATION

Employer's Name_____

Employer's Street Address _____

City _____ State _____ Zip Code _____

Employer's Tax I.D. Number (required) _____ PC (USA) PIN#:_____

Number of Employees Eligible for FSA: _____

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 ( ) _____

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 on to the Online Group Service Center)

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address_____

Additional Contact Person has access to the following when contacting Further:

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

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

II. HEALTH PLAN ADMINISTRATIVE INFORMATION

The Board of Pensions EPO or PPO medical options or other group health coverage (not a high deductible plan) must be offered in order to offer an FSA.

Which medical options do you offer (check all that apply)?

☐ EPO ☐ PPO ☐ Non Board of Pensions (Describe)_____

III. FLEXIBLE SPENDING ACCOUNT ADMINISTRATIVE INFORMATION

Plan Year

FSA start date _____ FSA plan year end date **12/31/2024**

Plan Options *(select **all** that apply)*

☐ Healthcare Flexible Spending Account
☐ Dependent Care Flexible Spending Account

Section 125

You must have a Section 125 plan in place to allow employee pretax contributions to the FSA. Further will set up a Section 125 plan.

Eligibility Required for Plan documents *(generally matches that of the health plan.)*

Employees must work at least 20 hours per week to be eligible for the Healthcare Flexible Spending Account

There are no hourly requirements for the Dependent Care Flexible Spending Account

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

Minimum and Maximum Employee Contribution Limits

	Minimum	Maximum	
Healthcare FSA	$_____	$_____	**(IRS maximum is $3,200)**
Dependent Care FSA	$_____	$_____	**(IRS maximum is $5,000)**

Does the Employer contribute to any account(s)? ☐ Yes ☐ No (default)

If yes, indicate which accounts:

☐ Healthcare
☐ Dependent Care

Note: The employer can contribute up to $500 for all eligible members without the employee contributing. When employer is contributing an amount over $500, the employer's contribution cannot exceed the employee's election (per IRS requirements).

Rollover

The plan allows employees to roll over up to $640 from the current plan year to their FSA for the following plan year (only $640 can roll over, any remaining balance that exceeds $640 is forfeited). The rollover amount does not count towards the annual FSA contribution limit.

Runout Period

The runout period is the deadline for participants to submit claims for the previous plan year. All eligible claims must be received by Further by the end of the runout period.

The runout period selected for a healthcare FSA is 3 months from the end of the plan year (March 31).

IV. REIMBURSEMENT

- Employees use the debit card to pay for qualified healthcare expenses just as they would use a bank debit card. All participants will be issued one debit card. A debit card for dependent(s) may be requested online at no cost.
- Dependent Care can only be reimbursed using a claim form or by submitting an online request as noted below.
- Online Requests - Employees request reimbursement through our secure online member service center at hellofurther.com.

Copay amounts

The copay amounts for healthcare coverage have been provided by the Board of Pensions. This will allow the copay amounts to auto-substantiate when the debit card is used. Documentation will not be required for reimbursement for these copays.

V. ENROLLMENT DATA

Employers are required to enroll participants online using the Online Group Service Center at hellofurther.com (for electronic file options, call the Employer Service Line toll free at: 888-460-4013).

VI. FSA PAYROLL INFORMATION

Further is required to post payroll deduction information throughout the year for all employees choosing to participate in the plan. Funds should **not** be sent with any deduction information.

We offer two options for sending us your payroll deduction data:

☐ **Online Group Service Center (recommended)**: You can create and upload a file directly in the Further system or manually enter contribution amounts.

☐ **Electronic File**: This option requires employers to create a file using the Further format requirements (Contact the Employer Service Line toll free at: 888-460-4013 for file format requirements).

VII. ADMINISTRATIVE FEES

FSA administrative fees - $3.90 per account per month

You will receive an automated email notification when your detailed billing information is available and another email notification two business days in advance of the scheduled Automated Clearing House (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 Clearing House (ACH) Information

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

Use bank account information indicated below:

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.)

VIII. CLAIM REIMBURSEMENT PROCESSING

When Further reimburses claims from an FSA to the member, Further will need to collect the funds from the employer. This is accomplished via an ACH funds withdrawal from an account indicated here. Prior to initiating an ACH, Further will send an email to the contact person indicating the amount and date funds will be withdrawn from the employer's account. This is scheduled weekly.

Automated Clearing House Information ***(completion of this section is mandatory)***

I hereby authorize Further to charge our bank account through Automated Clearing House for **claim reimbursements** made to our employees. The following bank account information is provided to Further for initiation of this procedure.

☐ **Use same bank account as indicated for Administrative Fees**
☐ Use different banking account information - please fill out information below:

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. ADMINISTRATIVE TIPS

PLAN DOCUMENTS: Further will be preparing your Plan Document and Summary Plan Descriptions (SPD). The documents will be sent to the group contact within 60 days of receipt of the completed Employer Enrollment Form.

X. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another administrator? (This would include if your plan had rollover from the prior year.) ☐ Yes (If yes, fill out the fields below.) ☐ No (If no, skip to the signatures section.)

PRIOR ADMINISTRATOR INFORMATION:

Please provide us with the prior administrator's name:

Name _____

PLAN YEAR INFORMATION:

Please select one of the following and fill out the corresponding section.

☐ **TAKEOVER AT NEW PLAN YEAR:**

Please select the administrator that will be processing the runout claims for the previous plan year.
Note: If you have a grace period on your current FSA account, it is recommended that Further take over at the renewal date to reduce duplicate claim submissions.

☐ The prior administrator ☐ Further (recommended if grace period is applicable)

Healthcare FSA –

☐ Grace Period Grace Period End Date: _____
☐ Runout Period Runout Period: _____ months
☐ Rollover Rollover Amount: _____

Dependent Care –

☐ Grace Period Grace Period End Date: _____
☐ Runout Period Runout Period: _____ months

☐ **TAKEOVER AT MIDYEAR:**

What is the last date the prior administrator will process claims? _____

What is the date that the enrollment data and balances will be submitted to Further? _____

Please note: There will be a blackout period between when the data is received and when Further will begin to process claims. The plan will be set up according to the plan design guide submitted to Further.

XI. SIGNATURES

It is agreed that necessary information concerning current and future employees or 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 _____