

## **PBS Health Savings Account Setup**

		11.00						
Employer Demographic Information								
Employer Name:								
Plan Information								
Plan Effective Date:		Plan Year Begins:	Plan Year	Plan Year Ends:				
1 <sup>st</sup> Payroll Date:	Open I	Enrollment Dates:	to	to				
Payroll Frequency:	Weekly(52) B	i-Weekly(26) Se	emi Monthly(24)	Monthly(12)				
*Payroll contributions are required to be funded within 5 business days after being withhelf from pay								
Plan Name:								
Plan Trustee(s): Do you have other pl	ans in place: Yes	No						
Eligibility								
Does plan eligibility n	match group health	plan? Yes N	0					
Employee Hour Requ	irement (per week):	Emp	oloyee Age Require Maximum of 21	ment:				
Length of Service:	None 1 Month 2 Months							
Date of Eligibility:	1st of the month or immediately following fulfillment of eligibility conditions							
Exclusions or Notes:								
Regulatory Limits (as of 2024)								
Contribution Benefit	Limit - \$4,150(empl	oyee)/\$8,300(famil	y) Catchup (over	age 55 - \$1,000)				
	Health Savir	ngs Account (HSA)	Limited Purpose (LPHSA)					
Is this a takeover?	Yes No		Yes No					
If yes, are the existing HSA accounts going to be converted to LPFSA? Yes No								
Offer Benefits Card? Yes No			Yes No					
Employer	Yes No		Yes No					
Contributions								
If yes, please list amount and freque	Amount:		Amount:  Frequency:  (payroll, quarter, etc.)	ollar or % of comp 				

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Authorizing Initials: \_\_\_\_\_\_ Date: \_\_\_\_\_



## **Professional Benefit Services Master Application**

Employer Demographic Information										
Employer Name:										
Mailing Address:					City:	ty:				
Mailing Address Lir	ne 2:				State: ZIP Code:					
Company Website	(if any):					Fiscal Year End(mm/dd): /				
Employer EIN:	Principal Business					Activity:				
Total # of EE's:	Total # of Benefit Eligible EE's: # of EE's on GHP:							:		
Business Entity: ☐ C-Corp ☐ *Sub S-Corp ☐ *LLC ☐ Other (specify):										
	*Partners	hip 🔲	Non-	-Profit	■*Sole	Prop				
*Please note that owners of LLC, S-Corps, Sole Proprietorships and Partnerships cannot participate. Premium Only Plans can only be use for group medical premiums.										
First Payroll After P	lan Start:			Ν	umber	of Pay	rolls	per Year:		
		Aut	thoriz	zed Plar	n Conta	icts				
Primary Plan Contact Name:										
Phone Number:		F	ax:			Ema	ail:			
Secondary Plan Contact Name:										
Phone Number:	Fax: Email:									
		Advi	sor/E	Broker I	nforma	ition				
Advisor Name:										
Phone Number:		F	ax:			Ema	ail:			
				Service	S.					
Type of Plans:  Premium Only Plan (POP) Premium Only Plan (POP) with HSA Premium Only Plan with HSA and Dependent Day Care Full Cafeteria Plan (FSA) Dependent Care FSA (DCA)  Health Reimbursement Account (HRA) Limited Purpose Cafeteria Plan (LPFSA) Transportation Account Parking Account COBRA Retiree										
Fees										
Selected Services:	One Ti Set-Up		Adm	nin Fee	Mi Mon Fe	thly		Annual ewal Fee		Notes
Authorized Signature: Date:										