



New Group Application

Client Information

Client Name:

Client DBA (if applicable):

Client Address:

City:

State:

Zip:

Federal Tax ID:

Employer Organization State:

Employer Organizational Type: _____

(Corporation, Limited Liability Company, Partnership, S Corporation, Sole Proprietorship, Non-Profit Organization, Estate, Professional Corporation, Governmental Entity or Church)

Client Contact Information

The “**Signatory Contact**” should be the individual authorized to sign/execute the legal plan documents at the organization. All individual(s) listed below will be provided with Employer Administrative Access, and any other OCA issued communications.

Primary Contact:

Title:

Primary Email:

Primary Phone:

Signatory Contact:

Title:

Signatory Email:

Signatory Phone:

Broker Contact Information

Primary Broker Contact:

Primary Broker Email:

Additional Broker Contact:

Additional Broker Email:

Broker Firm:

General Agency:

Invoicing Set-up

Invoice Remittance Information –Responsible for Paying OCAs Administrative Fees

Who is responsible for paying OCA’s administrative fees? ☐ Employer ☐ Other: _____

Invoice Contact Name:

Invoice Contact Email:

Phone:

Method of Payment Options:

☐ ACH Draft ☐ Credit Card ☐ Check

Do invoices need to be issued by division?

☐ Yes ☐ No (If yes, please provide divisional name(s) below. This form should be repeated for each division if separate banking is required)

Divisional Names: _____

Bank Account Information – Required for ACH Draft

Bank Name:

Routing Number (9 Digits):

Account Number (Include leading 0’s):

Invoicing Details & Bank Filter Information

OCA’s invoicing process is scheduled for the 1st week of every month, with generated invoices reflecting services provided in the previous month; for instance, June's invoice will pertain to services rendered in May. Furthermore, if ACH is chosen for the admin fee payment, OCA will automatically withdraw the monthly administrative fee on or around the 15th of each month. Additionally, your bank should be provided with OCA’s banking filters and placed on the “approved” list. This is particularly important when employers offer employees the ability to be reimbursed via direct deposit and/or employees are issued OCA’s debit card.

We recommend you notify your bank with the following bank filters:

OCA Admin Fees/ACH Pull

- ACH Vendor: TransFirst Sponsor Bank (aka TransCentral)
- Merchant ID: 1752598308

Direct Deposit/Debit Card Reimbursements (if applicable)

- Submitting Bank: HARRIS BANK F/K/A M&I
- COMPANY ID (Daily POS Settlements): 1383261866
- COMPANY ID (ACH RESUBMITS): W383261866
- COMPANY ID (MANUALS): 3W38326186
- BANK COMPANY NAME: Med-I-Bank or MBI
- ROUTING NUMBER: 075000051

HSA Clients Only (if applicable for payroll contributions)

- Company ID (HSA Items): I900808825
- Submitting Bank (HSA Services): HSAWCSPCUSTODIAN
- Company ID (Payroll Funding): 071000288
- Routing Number: 075072157

Individual Coverage Health Reimbursement Arrangement (ICHRA)

Please complete this section if offering multiple ICHRAs.

ICHRA Plan Name: _____

Takeover from another ICHRA administrator?

☐ Yes ☐ No

If yes, will OCA be managing the run-out period from the past or current plan year? ☐ Yes ☐ No

ICHRA Effective Date: ____/____/____
(MM/DD/YYYY)

Plan No: 504 (Unless otherwise specified, this will be the number referenced throughout the Plan Documents.)
Alternate Plan No. (if Applicable): _____

ICHRA Plan Year Cycle: ☐ Calendar Year **or** ☐ Plan Year – Runs ____/____ thru ____/____
(MM/DD) (MM/DD)

Employee Class(es)

Which permissible "class(es)" of employees will be offered the ICHRA?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Full - Time | <input type="checkbox"/> Temporary employees working for staffing firm |
| <input type="checkbox"/> Part - Time | <input type="checkbox"/> Employees covered under a collective bargaining agreement |
| <input type="checkbox"/> Seasonal | <input type="checkbox"/> Employees in a waiting period |
| <input type="checkbox"/> Salaried | <input type="checkbox"/> Foreign employees who work abroad |
| <input type="checkbox"/> Hourly | <input type="checkbox"/> Employees in different locations, based on rating areas |

An ICHRA must be offered on the same terms and conditions to all employees within a class, except that the ICHRA benefit amount may increase based on age (by up to three times the maximum dollar amount available to the youngest participant) or family size (i.e., number of dependents, coverage tier).

ICHRA Funding Schedule

ICHRA amounts are funded: ☐ Annual ☐ Semi-Annually ☐ Quarterly ☐ Monthly (Recommended)

If "annual" is selected, the full ICHRA limit is available on the 1st day of the plan year.

New-Hire Contributions (For Mid-Year Enrollments)

Will ICHRA contributions be pro-rated for new hires during the plan year?

☐ No ☐ Yes

*If yes, **for new hires only**, OCA will pro-rate the HRA based upon the # of months remaining in the plan year. If no, OCA will make the full annual amount available for mid-year new hire enrollments.*

ICHRA Funding Limits

Will the ICHRA funding limits be determined based on age? ☐ Yes ☐ No

If yes, please complete OCA's ICHRA employee census template and identify the **monthly** ICHRA funding limit for each employee.

ICHRA Reimbursement Caps (Complete if funding is based on coverage tiers/# of dependents)

Employee: \$_____	EE/Child(ren):\$_____	EE + Spouse: \$_____	Family: \$_____
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Note: The above \$ amount will be allocated based upon the funding schedule selected on the previous page.

Will unused HRA Funds Carryover into the next plan year? ☐ Yes ☐ No

If yes, please explain carryover option here:_____

Employee Contributions (Optional)

Allow employees to contribute their own funds to cover insurance premium difference? ☐ Yes ☐ No

If yes, please complete OCA's ICHRA employee census template and identify the employee **monthly** contribution.

Note: Employers can allow employees to use pre-tax cafeteria plan salary reductions to pay the portion of the premiums for their individual medical coverage not covered by the ICHRA, so long as the coverage is purchased outside of an Exchange and subject to applicable cafeteria plan guidance.

Eligible ICHRA Expenses (Select all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Individual Insurance Premium | <input type="checkbox"/> All Copays | <input type="checkbox"/> Dental Expenses |
| <input type="checkbox"/> In-Network Deductible | <input type="checkbox"/> Office Visit Copays | <input type="checkbox"/> Vision Expenses |
| <input type="checkbox"/> Rx Deductible | <input type="checkbox"/> Rx Copays | <input type="checkbox"/> All 213(d) Eligible Expenses |
| <input type="checkbox"/> Out-of-Network Deductible | <input type="checkbox"/> ER Copays | <input type="checkbox"/> All Rx/Prescriptions |
| <input type="checkbox"/> In-Network Coinsurance | <input type="checkbox"/> Hospital Copays | <input type="checkbox"/> Over-the-Counter Drugs |
| <input type="checkbox"/> Out-of-Network Coinsurance | <input type="checkbox"/> Other Copays:_____ | <input type="checkbox"/> Other: _____ |

ICHRA Run-Out Period

Active Employees Run Out: ☐ 90 Days (recommended) ☐ 60 Days ☐ 30 Days ☐ Other (# of days): _____

Termed Employees Run Out: ☐ 90 Days from Termination ☐ Other : _____

Comments

Benefit Debit Card Information

Please indicate which lines of service the card should be related to:

☐ HRA ☐ FSA ☐ Commuter ☐ Lifestyle Account

Default Card Shipping Location:

☐ Employee Mailing Address ☐ Employer Address

If nothing is selected, OCA will default to shipping cards to the employee mailing address on file.

FSA Debit Card Set-Up

- ☐ IIAS Approved Pharmacies
- ☐ Medical Providers (i.e., Doctors office, Hospitals)
- ☐ Dental Providers
- ☐ Vision Providers

HRA Debit Approved Merchants

HRA Approved Merchants (select all that apply):

- ☐ IIAS Rx Prescriptions Approved Pharmacies
- ☐ Medical Providers (i.e., Doctors office, Hospitals)
- ☐ Dental Providers
- ☐ Vision Providers
- ☐ Insurance Carrier (ICHRA Only)

HRA Debit Card Payment Option:

- ☐ Pay 100% of Card Transaction
- ☐ Pay _____% of Card Transaction
- ☐ Pay Set Amount:

\$_____ Per RX \$_____ Per Office Visit \$_____ Per ER Visit \$_____ Per Hospital

\$_____ Per Other: _____

Lifestyle Spending Approved Merchants

(OCA may request additional information to verify all available Merchant Category Codes (MCCs))

- | | | | |
|-----------------------------------|--|--|---|
| <input type="checkbox"/> Auto | <input type="checkbox"/> Finance | <input type="checkbox"/> Pets & Pet Care | <input type="checkbox"/> Fitness |
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Home & Home Office | <input type="checkbox"/> Personal Care | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Food | <input type="checkbox"/> Insurance & Utilities | <input type="checkbox"/> Education | <input type="checkbox"/> Family Care |

Claims Reimbursement – Employer Bank Account Set-Up

This employer bank account will be for claims/debit card transactions. If this account is the same as the account listed under the “Invoice Set-up” page, you do not need to re-enter employer banking information. Additionally, upon account set-up, a non-refundable \$1.00 pre-note will be drafted on this account. This pre-note serves to verify that OCA has the correct account/routing information on file.

Bank Name:

Routing Number (9 Digits):

Account Number:

Use the employer bank account for the following services:

- ☐ All Lines of Service
- ☐ HSA (Health Savings Account)
- ☐ HRA (Includes HRA, ICHRA, EBHRA, QSEHRA)
- ☐ FSA (Includes Health FSA, Dependent Care, Limited Purpose FSA)
- ☐ Commuter (Includes Transit and Parking)
- ☐ LSA (Lifestyle Spending Account)

Do you wish to use different bank accounts for different divisions? ☐ Yes ☐ No

If yes, please verify the division name below. You will need to complete this form for each division.

Division Name: _____

Claims Reimbursement Options

Please select the allowable reimbursement options below:

- ☐ Debit Card Transactions ☐ Direct Deposit Reimbursements ☐ Check Reimbursements (see below)

Manual Claims Reimbursement Schedule: OCA will process claims daily, unless specified here: _____

Note: Debit card reimbursements will occur daily regardless of manual claims schedule

Check Reimbursements (If Applicable)

For check reimbursements, please provide the starting check number OCA should be using: _____

There is no need to order check stock, OCA uses our own supply. Reimbursement checks will be issued from the designated employer bank account provided in this application.

Do you want reimbursement checks sent directly to the employee? ☐ Yes ☐ No

Do you want reimbursement checks sent directly to the provider (HRA Clients Only)? ☐ Yes ☐ No

If the answer is yes to either of the above questions, please provide the signature of the authorized signer in the designated signature box below.

Additionally, if the employer authorized signature is provided to OCA, checks can only be mailed to either the employee mailing address or provider address. Checks cannot be sent in bulk to the employer.

Authorized Signature:

The signature provided above will be included on the physical check reimbursements. Please do not type your name nor provide an electronic timestamp as your signature.

Commonly Asked Compliance Rules & Definitions – IMPORTANT PLEASE READ

Employee Reimbursement Checks: If the employer authorized signature is provided to OCA, reimbursement checks can only be mailed to either the employee mailing address or provider address, ensuring security and accuracy in distribution. However, if the employer authorized signature is not provided, OCA will bulk mail check reimbursements to the employer address for signature and distribution to employees, streamlining the process while maintaining necessary protocols.

Ownership Eligibility Rules: Only “employees” can participate in a Cafeteria Plan (FSA, DCA, Commuter) and/or Health Reimbursement Arrangement (HRA) on a tax-favored basis. Thus, while partnerships, sole proprietorships and Sub-Chapter “S” Corporations may sponsor Cafeteria Plans, the following cannot participate on a tax-favored basis: sole proprietors, partners, and greater than 2% shareholders in Sub-Chapter “S” Corporations, as well as direct family members (spouses, siblings, parents, and children) of the greater than 2% owner. When the employer agrees to reimburse up to a specified amount of medical expenses incurred during a plan year for non-eligible participants, the compensation that the employer is providing under the Code to the “employee” is the value of medical coverage. The value of coverage is the fair market value of the coverage without regard to whether the employee utilizes the coverage in full. Please consult with your CPA for confirmation or further guidance as OCA does not render tax or legal advice.

Run-Out Period: A run-out period is a pre-determined time frame after the plan year ends. During the run-out period, employees may file HRA, FSA and dependent care claims for expenses incurred during the prior plan year.

Terminated Employee Runout Period: A terminated employee run-out period is a pre-determined time frame beginning the day after termination or after the plan year ends, which is typically a different run-out period than used for current employees.

75-Day Grace Period: Money unspent at the end of the plan year can now be rolled over into the next plan year for 2.5 months. Thus, employees contribute for 12 months but have 14.5 months to incur expenses and use up the remaining money. The maximum grace period is until the 15th day of the third calendar month after the end of the plan year. (This can apply to the Health FSA, Limited Purpose FSA, and the Dependent Care Account).

FSA Carryover: An FSA carryover is the amount of unused FSA funds the Internal Revenue Service (IRS) allows plan participants to carry from one year to the next plan year. There is an annual maximum that can be carried over from one year to the next which is typically 20% of the maximum allowable yearly contribution. (This can apply to the Health FSA or Limited Purpose FSA. It does NOT apply to the Dependent Care Account).

HRAs & COBRA: An Employer is entitled to bill COBRA participants 1/12th of the HRA maximum benefit (plus 2% administrative surcharge) unless the rollover option is selected. With the rollover option an actuary MUST be retained to determine COBRA premium for the HRA. The HRA is not available to participants selecting coverage under the NJ Dependent to Age 31 or most state continuation programs. Any unused COBRA contributions that are paid to the employer remain the employer’s property at the conclusion of the Plan year run-out period. Conversely, Employers are responsible for funding the full amount a COBRA participant’s claim through the HRA, even in cases when they haven’t fully contributed their portion. An organization subject to COBRA is legally bound to offer the HRA.

Aggregated: Is where all members of the families’ claims count towards one up-front responsibility and/or the maximum reimbursement cap.

Non-Aggregated: Is where each family member has an individual responsibility in addition to the overall family responsibility.

Lifestyle Accounts/Tax Implications: LSAs are generally a taxable benefit to the employee and employer. Only used funds are considered taxable income. Please keep this in mind when identifying how/when tax withholdings take place. Many clients withhold the Lifestyle benefit value (i.e. \$3,000) throughout the entire plan year to limit and surprise tax withholdings at the end of the year or when a claim is incurred. In this example, any taxes previously withheld for unused Lifestyle funds can be credited back to the employee.