Initial Client Information

Employer's Legal Name:

Mailing Address: City: State: Zip:

Street Address: City: State: Zip:

Tax ID: State Organized: Industry: (Ex. Bank or Retail)

Divisions? □ Yes* □ No *If Yes – List Divisions:

Is separate reporting needed for divisions? □ Yes* □ No *If Yes – Divisional reporting/billing notes:

Type of Company: (Circle One) C-Corp. S-Corp.* Partnership Sole Prop. Non Profit Other:

* A self-employed individual, partner or person who owns more than 2% of the outstanding stock is not eligible to enroll

Total Number of Employees: Number of Benefit Eligible Employees:

Primary Contact: Title:

E-Mail: Telephone: ( ) Fax: ( )

Secondary Contact: Title:

E-Mail: Telephone: ( ) Fax: ( )

Agency: Broker:

Copy Broker on all set-up, renewal and escalated emails: □ Yes □ No

E-Mail: Telephone: ( )

□ Health Savings Accounts (HSA)
□ Commuter Choice (Parking & Transit)
□ Flexible Spending Accounts (FSA)
□ Health Reimbursement Arrangement (HRA)
□ Dependent Care Account (DCA)

Intended TPA Effective Date: Fiscal Year End Date:

Plan Year: (Ex. January 1 – December 31)

□ Short plan year (If short plan is FSA- Proration of Dependent Care election is required; Health Care is recommended)

Plan Notes:

(please note here if plan start dates or effective dates are different for multiple plans)