

NEW CLIENT INSTALLATION SHEET

THIS SECTION TO BE COMPLETED BY CONSULTANT

CONSULTANT: [] JESUS HERRERA [] _____

DATE INSTALLATION SHEET RECEIVED BY FLEX CORP: ____/____/____

TYPE OF PLAN: [] FULL PLAN [] PREMIUM ONLY [] PREMIUM REIMBURSEMENT [] HRA [] MCRP [] DCAP [] HSA

CLIENT INFORMATION - THIS SECTION TO BE COMPLETED BY CLIENT

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

MAIN TELEPHONE NUMBER: (____) ____ - _____ MAIN FAX NUMBER: (____) ____ - _____

PRIMARY CONTACT: _____

E-MAIL: _____ DIRECT LINE: (____) ____ - _____ DIRECT FAX: (____) ____ - _____

BILLING CONTACT: _____

E-MAIL: _____ DIRECT LINE: (____) ____ - _____ DIRECT FAX: (____) ____ - _____

BUSINESS INFORMATION - THIS SECTION TO BE COMPLETED BY CLIENT

CLIENT BUSINESS CODE (SIC): _____ DESCRIPTION OF BUSINESS: _____

UNION EMPLOYEES: [] YES [] NO

IF YES, ARE UNION EMPLOYEES ALLOWED TO PARTICIPATE IN THE CAFETERIA PLAN? [] YES [] NO

CLIENT FISCAL YEAR END: _____ DOES CLIENT PAY FICA?: [] YES [] NO EMPLOYER'S EIN #: _____

DOES CLIENT FILE A FORM 5500 FOR ANY OF THE WELFARE BENEFITS OFFERED? [] YES (ATTACH COPY) - PLAN # _____ [] NO

PLAN # THAT FLEX CORP SHOULD USE: _____

TYPE OF BUSINESS ENTITY (CHECK ALL THAT APPLY): [] CORPORATION [] SUBCHAPTER S [] PARTNERSHIP [] TAX-EXEMPT [] C-CORP [] SOLE PROPRIETORSHIP [] GOVERNMENTAL [] PUBLICLY TRADED - CUSIP #:

DOES THIS PLAN NEED A BOARD RESOLUTION? [] YES [] NO

IF YES, PLEASE STATE TYPE: [] BOARD OF DIRECTORS [] PARTNERS [] OTHER: _____

PLEASE LIST ALL AFFILIATED COMPANIES/CONTROLLED GROUP INFORMATION:

Table with 4 columns: NAME, ADDRESS, EIN, RELATIONSHIP. Multiple rows for listing companies.

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PLAN & ELIGIBILITY INFORMATION - THIS SECTION TO BE COMPLETED BY CLIENT

EFFECTIVE DATE OF OUR SERVICE: ___/___/___

ANTICIPATED ENROLLMENT DATES: ___/___/___ AND ___/___/___ AND ___/___/___

SHORT PLAN YEAR BEGINS: ___/___/___ SHORT PLAN YEAR ENDS: ___/___/___

FULL PLAN YEAR BEGINS: ___/___/___ FULL PLAN YEAR ENDS: ___/___/___

- POP PLAN, MEDICAL REIMBURSEMENT PLAN, DEPENDENT CARE REIMBURSEMENT PLAN, PREMIUM REIMBURSEMENT PLAN, HEALTH REIMBURSEMENT ARRANGEMENT. Includes checkboxes for New, Take Over, Original Effective Date, Mid Year, Yes/No.

POP - ELIGIBILITY REQUIREMENTS: ___ HOURS PER WEEK ___ DAYS. FIRST OF THE MONTH [] YES [] NO: _____

MEDICAL CARE REIMBURSEMENT PLAN - ELIGIBILITY REQUIREMENTS: [] N/A [] SAME AS ABOVE [] NO. IF NO, ELIGIBILITY IS: ___ HOURS PER WEEK ___ DAYS. FIRST OF THE MONTH [] YES [] NO: _____

DEPENDENT CARE ASSISTANCE PLAN - ELIGIBILITY REQUIREMENTS: [] N/A [] SAME AS ABOVE [] NO. IF NO, ELIGIBILITY IS: ___ HOURS PER WEEK ___ DAYS. FIRST OF THE MONTH [] YES [] NO: _____

PREMIUM REIMBURSEMENT ACCOUNT - ELIGIBILITY REQUIREMENTS: [] N/A [] SAME AS ABOVE [] NO. IF NO, ELIGIBILITY IS: ___ HOURS PER WEEK ___ DAYS. FIRST OF THE MONTH [] YES [] NO: _____

HEALTH REIMBURSEMENT ARRANGEMENT - ELIGIBILITY REQUIREMENTS: [] N/A [] SAME AS ABOVE [] NO. IF NO, ELIGIBILITY IS: ___ HOURS PER WEEK ___ DAYS. FIRST OF THE MONTH [] YES [] NO: _____

PLAN DESIGN - THIS SECTION TO BE COMPLETED BY CONSULTANT

WILL PLAN ALLOW OVER-THE-COUNTER? [] YES [] NO WILL PLAN ALLOW THE GRACE PERIOD? [] YES [] NO

WILL PLAN ALLOW DEBIT CARDS? [] YES [] NO

CO-PAYS: DR.: _____ RX: _____

MEDICAL CARE REIMBURSEMENT PLAN: MAX. ANNUAL CONTRIBUTION: \$ _____ MIN. ANNUAL CONTRIBUTION \$ _____. FLOAT: [] YES, \$ _____ [] NO

DEPENDENT CARE ASSISTANCE PLAN: MAX. ANNUAL CONTRIBUTION: \$ _____ MIN. ANNUAL CONTRIBUTION \$ _____. FLOAT: [] YES, \$ _____ [] NO

HEALTH REIMBURSEMENT ARRANGEMENT (HRA): MAXIMUM ANNUAL CONTRIBUTION: \$ _____

CARRY OVER: [] YES [] NO. FULL ANNUAL AVAILABLE AT ANY TIME DURING THE PLAN YEAR? [] YES [] NO - IF NO, PARTICIPANT WILL ONLY BE REIMBURSED UP TO THE PARTICIPANTS ACTUAL AVAILABLE ACCOUNT BALANCE.

COVERED EXPENSES: _____

EXCLUSIONS: _____

PLAN NOTES: _____

NEW CLIENT INSTALLATION SHEET

CAFETERIA PLAN BENEFITS (PLEASE CHECK ALL THAT APPLY) - THIS SECTION TO BE COMPLETED BY CLIENT

- | | |
|---------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> MEDICAL | <input type="checkbox"/> CANCER CARE |
| <input type="checkbox"/> DENTAL | <input type="checkbox"/> GROUP TERM LIFE INSURANCE |
| <input type="checkbox"/> VISION | <input type="checkbox"/> ACCIDENTAL DEATH & DISMEMBERMENT |
| <input type="checkbox"/> HEALTH SAVINGS ACCOUNT | <input type="checkbox"/> SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT |
| <input type="checkbox"/> LONG TERM DISABILITY | <input type="checkbox"/> VACATION BENEFIT |
| <input type="checkbox"/> OTHER: | |
| <input type="checkbox"/> SPENDING CREDITS - \$ _____ DETAILS: _____ | |

ENROLLMENT INFORMATION - THIS SECTION TO BE COMPLETED BY CLIENT

- NUMBER OF EMPLOYEES: _____
- FLEX CORP ENROLLMENT FORM: YES NO - IF NO, PLEASE PROVIDE COPY FOR APPROVAL
- NUMBER OF SPANISH FORMS NEEDED: _____
- NUMBER OF OVERVIEWS NEEDED: _____
- PACKETS WILL BE: MAILED E-MAILED

PLEASE PROVIDE THE FOLLOWING PER PAY PERIOD INFORMATION ON THE BENEFITS TO BE OFFERED UNDER YOUR CAFETERIA PLAN. IF YOU HAVE MORE THAN ONE PAYROLL CYCLE, PLEASE COMPLETE THIS SECTION FOR EACH PAYROLL CYCLE.

- PAYROLL PERIOD: MONTHLY SEMI-MONTHLY WEEKLY BI-WEEKLY

MEDICAL PLAN #1 REFERRED TO AS: _____

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + SPOUSE:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + CHILD(REN)	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + FAMILY	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____

MEDICAL PLAN #2 REFERRED TO AS: _____

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + SPOUSE:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + CHILD(REN)	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + FAMILY	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____

MEDICAL PLAN #3 REFERRED TO AS: _____

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + SPOUSE:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + CHILD(REN)	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + FAMILY	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____

DENTAL PLAN #1: TYPE: _____

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + SPOUSE:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + CHILD(REN)	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + FAMILY	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____

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ENROLLMENT INFORMATION CONTINUED FROM PREVIOUS PAGE - THIS SECTION TO BE COMPLETED BY CLIENT

DENTAL PLAN #2: TYPE: _____

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + SPOUSE:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + CHILD(REN)	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + FAMILY	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____

VISION PLAN:

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + SPOUSE:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + CHILD(REN)	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + FAMILY	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____

OTHER INSURANCE: _____

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + SPOUSE:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + CHILD(REN)	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____
EMPLOYEE + FAMILY	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____

CANCER CARE:

EMPLOYEE ONLY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____	PER MONTH
EMPLOYEE + FAMILY:	TOTAL PREMIUM \$ _____	EMPLOYEE CONTRIBUTION \$ _____	PER MONTH

LIFE AND AD&D:

MAXIMUM AVAILABLE BENEFIT IS: _____

THE RATES ARE \$ _____ **PER THOUSAND FOR LIFE INSURANCE AND \$** _____ **PER THOUSAND FOR AD&D.**
OF THIS THE EMPLOYEE CONTRIBUTES \$ _____ **PER THOUSAND COMBINED LIFE AND AD&D.**

LONG TERM DISABILITY:

MAXIMUM AVAILABLE BENEFIT IS: _____

THE RATES IS \$ _____ **PER THOUSAND OF COVERED PAYROLL.**
OF THIS THE EMPLOYEE CONTRIBUTES \$ _____ **PER THOUSAND OF COVERED PAYROLL.**

PLEASE LIST ALL OFFICERS: (THESE ARE OFFICERS WITH ADMINISTRATIVE DUTIES AND NOT OFFICERS IN TITLE ONLY.)

PLEASE LIST ALL EMPLOYEES WHO:

- (a) ARE A 5% OWNER; OR**
- (b) ARE A 1% OWNER AND HAVE AN ANNUAL COMPENSATION GREATER THAN \$150,000**

**PLEASE PROVIDE A CENSUS FILE IN AN .XLS FORMAT. FILE TO INCLUDE THE FOLLOWING FOR ALL EMPLOYEES:
 SOCIAL SECURITY NUMBER, EMPLOYEE FIRST NAME, EMPLOYEE LAST NAME, ADDRESS, DATE OF BIRTH AND DATE OF HIRE**

NEW CLIENT INSTALLATION SHEET

BANKING, BILLING AND FEES – THIS SECTION TO BE COMPLETED BY CONSULTANT

FLEX CORP TO MAINTAIN FIDUCIARY ACCOUNT: YES NO

IF YES, FUNDING WILL BE: CHECK WIRE TRANSFER DIRECT DEBIT

IF NO, PLEASE PROVIDE THE FOLLOWING:

COMPLETED MICR ENCODING SHEET BANK SIGNATURE CARDS DIRECT DEBIT AUTHORIZATION

FREQUENCY OF PAY PERIODS:

MONTHLY

SEMI-MONTHLY - FIRST PAY PERIODS: ____/____/____ AND ____/____/____

WEEKLY - FIRST PAY PERIODS: ____/____/____ AND ____/____/____

BI-WEEKLY – IF BI-WEEKLY 24 OR 26 - FIRST PAY PERIODS: ____/____/____ AND ____/____/____

BILLING PREFERENCE: MONTHLY SEMI-MONTHLY BI-WEEKLY WEEKLY

WILL CLIENT HAVE SEPARATE BILLING GROUPS: YES NO

IF YES:	ASSOCIATION/LOCATION	PAY PERIODS
		____/____/____
		____/____/____
		____/____/____

WHO PAYS THE PARTICIPANT FEES?: EMPLOYER EMPLOYEE

INSTALLATION FEE: \$ _____ ANNUAL RENEWAL FEE: \$ _____

BASE MONTHLY FEE: \$ _____ MINIMUM MONTHLY FEE: \$ _____

PER PARTICIPANT FEE: \$ _____ DEBIT CARD FEE: \$ _____ - PAID BY EMPLOYER EMPLOYEE

QUARTERLY STATEMENTS: SENT TO PARTICIPANT FEE: \$90 SENT TO CLIENT – NO CHARGE

ENROLLMENT PACKAGE FEE: \$ _____

ADDITIONAL BILLINGS: \$ _____

BROKER CONTACT INFORMATION – THIS SECTION TO BE COMPLETED BY CONSULTANT

ACCOUNT MANAGER: _____

COMPANY: _____

ADDRESS: _____

PHONE: (____) ____ - _____

FAX: (____) ____ - _____

E-MAIL: _____

ADDITIONAL NOTES:
