Allegiance℠ by Cigna Healthcare

New Group? ☐
Current Health Group? ☐
Health Group # _____
HSA JOINT? ☐

HEALTH SAVINGS ACCOUNT
Plan Checklist

ABPM Rep: ID#:

1. LEGAL NAME OF EMPLOYER

_____

EMPLOYER'S ADDRESS

_____
(Physical – address/zip code)

_____
(Billing Address)

_____.
(City) (State) (Zip)

Telephone _____

Fax # _____

2. CONTACT PERSONNEL (If more than 2, please attach)

Human Resources: _____

HR Phone: _____

HR E-Mail Address _____

Payroll Department: _____

PR Phone: _____

PR E-Mail Address _____

EMPLOYER'S TAX ID NUMBER

_____

3. DO YOU CURRENTLY HAVE A PLAN WITH ALLEGIANCE?

☐ No.
☐ Yes. Plan Type:
- ☐ Group Health Plan (If group health plan is Administered by Allegiance, claims exchange set up claims pulled to Expense Tracker).
- ☐ Health Reimbursement Arrangement (HRA)
- ☐ Health Flexible Spending Account (FSA) see below:

If Allegiance administers your current Health FSA, how would you like adjust your Plan to accommodate the HSA participant?
- ☐ HSA participants cannot have a Health FSA.
- ☐ HSA participants can participate in a limited FSA (answer below)
  - ☐ Dental, vision and qualifying OTC expenses.
  - ☐ Expenses in excess of HDHP deductible.

FOR
- ☐ All participants.
- ☐ Only HSA contributing participants.

AND, claims for medical expenses may only be submitted for
- ☐ The participant.
- ☐ The participant and all dependents.

Do you currently offer the Debit Card for your FSAs?
- ☐ Yes
- ☐ No. Would you like to offer Debit Cards for your FSAs?
  - ☐ Yes
  - ☐ No

4. EFFECTIVE DATE(S)

Initial HSA effective date _____

Allegiance effective date _____

5. EMPLOYER ENTITY

- ☐ Corporation
- ☐ S Corporation
- ☐ Governmental Entity or Church
- ☐ Limited Liability Corporation
- ☐ Non-Profit Organization
- ☐ Partnership
- ☐ Sole Proprietorship

6. CONDITIONS FOR ELIGIBILITY
- ✓ HSAs are available only to individuals with qualifying High Deductible Health Plan (HDHP) coverage.
- ✓ Not available to those receiving benefits under Medicare.
- ✓ Cannot provide first dollar coverage, with certain exceptions preventive care, dental, vision, limited-use FSA.

7. HSA CONTRIBUTIONS. Plan will provide for

☐ Salary reduction contributions ONLY (No Employer contribution)
☐ Employer contributions ONLY (No salary reductions)
☐ Both salary reductions AND Employer contributions

8. EMPLOYER CONTRIBUTIONS
For each Plan Year, Employer will contribute
- ☐ N/A
- ☐ _____% of compensation per participant
- ☐ $_____ per participant
- ☐ Discretionary amount determined by Employer

*All HSA contributions must be loaded each pay period via template (provided on the Employer Portal). If there is also a Flex Plan, employee elections must be loaded on the same file.

Indicate frequency of Employer Contributions:
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Quarterly
- ☐ Other: _____

9. DO YOU CURRENTLY HAVE A SECTION 125 PLAN FOR PRETAX PAYROLL CONTRIBUTIONS?

☐ Yes. (Remind your TPA add HSA contributions to your pre-tax plan documents)
☐ No.

Would you like Allegiance to set up a Section 125 Plan for Pre-Tax payroll contributions?

☐ Yes
☐ No

16. OPEN ENROLLMENT FOR HSA PARTICIPANTS

Allegiance will provide HSA Employee Election forms for Employer payroll entry. Demographic and enrollment files will be sent to the assigned Reimbursement Account Specialist for entry into the Allegiance system.

17. ALLEGIANCE will withdraw funds by ACH based on the uploaded contribution file.

18. INDIVIDUAL ACCOUNT TRANSFER

☐ **This is a new HSA. No account transfer.**

☐ **The group transfer process will be used for the existing individual HSAs.**

12. PAY CYCLE

Please attach the payroll calendar for the plan year.

Contributions will be posted based on this calendar. *All HSA contributions must be loaded each pay period via template (provided on the Employer Portal). If employer contributions will be made, please indicate the dates on the payroll calendar. In addition, if there is also a Flex Plan, employee elections must be loaded on the same file.

13. DEBIT CARDS

All participants will receive 2 debit cards

10. WILL MORE THAN ONE COMPANY BE COVERED UNDER THIS PLAN?

☐ No
☐ Yes.

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

Track account separately? ☐ Yes ☐ No

Note: if separate banking is needed please include divisional banking information. HSA fee billing can be separated by division.

11. ARE THERE SEPARATE DIVISIONS WITHIN THIS COMPANY?

No
☐ Yes

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

Track account separately? ☐ Yes ☐ No

(**NOTE:** Please attach additional affiliated Employer information)

If separate banking is needed please include divisional banking information. HSA fee billing can be separated by division.

14. BROKER NAME & ADDRESS

(Name)

(Company)

(Address)

(City) (State) (Zip)

(E-mail Address) (Telephone)

15. FEES

	FEES
Initial Set-Up Fee	
Per Participant/Month	$2.50
Minimum Monthly Fee	

- ✓ **HSA Check Distribution fee $2.00** charged to participant. If they sign up for Direct Deposit this will not be charged.
- ✓ **Printed HSA Summary Fee $2.00** Printed materials are posted to the employee portal. Participants are emailed each time a statement or notification is posted if the account has a valid email address. If the participant goes on-line and elects to receive paper statements and notifications, a $2.00 fee will be charged to their account with each mailing.
- ✓ **HSA Closure fee $25.00** charged to participant.
- ✓ **Termed employee $3.95** charged to the participant. The employee is allowed to keep the account open even after termination.

At the direction of the Employer named on the checklist form. It is understood that Allegiance Benefit Plan Management, Inc., is not engaged in the practice of law. Any unanswered questions may result in errors in the Plan produced by using the information from this worksheet. I understand that in preparing the requested reimbursement plan, Allegiance Benefit Plan Management, Inc., is utilizing information shown on this checklist to establish and set up the reimbursement plan you are requesting, which is not subject to ERISA. Allegiance Benefit Plan Management, Inc. makes NO REPRESENTATION OR WARRANTY OF ANY KIND, express or implied, including any warranties of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, nor is any opinion, expressed or implied, rendered by its attorneys as to the legal effect, sufficiency or tax qualification of any document utilizing Allegiance Benefit Plan Management, Inc., format. It is understood and agreed that this document should be reviewed and approved by the Employer's tax and legal counsel and that neither Allegiance Benefit Plan Management, Inc., nor its attorneys and accountants are acting as legal or tax advisors to the Employer. I hereby RELEASE, INDEMNIFY AND HOLD HARMLESS Allegiance Benefit Plan Management, Inc., its attorneys, employees, affiliates, directors and agents from any claim or liability attributable to any legal or other defect of the requested reimbursement plan.

Prepared by: _____

(Revised September 2024)

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Allegiance℠ by Cigna Healthcare

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

This authorization allows Allegiance Benefit Plan Management, Inc. to initiate electronic withdrawal from our Employer checking account in conjunction with services provided pursuant to the Administrative Services Agreement. This authority will remain in effect until cancelled in writing or until the termination or expiration of the Administrative Services Agreement.

As an authorized representative of the Employer, I understand that Allegiance Benefit Plan Management, Inc. may initiate a reversal of any entry made under this authorization if an error has been made. I understand that the financial institution at which Employer has the above account is required to provide to designated Employer representatives the procedures for resolving errors on entries made under this authorization. I understand that Allegiance Benefit Plan Management, Inc. will provide a written notice to designated Employer representative of the error within 24 hours.

The deduction amount will be communicated to the Primary Contact designated by Employer.

PLEASE PRINT

_____	_____
Employer Name	Financial Institution
_____	_____
Primary Contact	City/State
_____	_____
Authorized Signature	Date
_____	_____
Account Number	Routing and Transit Number

Please attach a copy of a voided check or bank note to confirm banking information noted above.

Confirmed date that Claims Based Funding should start_____

Claims payments releasing daily.

Reimbursement Accounts Employer Access Form

Plan Sponsor/Employer_________________________________

The following individuals are authorized on behalf of the plan to request and receive from Allegiance Benefit Plan Management, Inc. subject to the limitations of applicable federal regulations, access in the below categories; protected health information (PHI) on employees and their dependents; billing information; monthly reporting; and employee adding and terminating information. Such information shall only be used for legitimate plan administration payment or health care operations purposes recognized by applicable regulations, and Plan Administrator/Employer understand that use of this information for purposes other than plan administration, payment and health care operations is strictly prohibited and that civil and criminal penalties will apply to any individual who is found to have improperly used or disclosed PHI in a manner contrary to federal regulations.

Please contact your reimbursement accounts specialist with any questions or updates for your plans account access form.

KEY*	
Automatic Reports	Any report option below will include the Account Invoice, Enrollment Verification, Year-End Report and Open Enrollment Confirmation.
Funding Reports	Includes Employer Funding and Debit Card Funding
Full Access	Manage individual employee data on employer dashboard, importing/viewing new files, view plans, request reports, view/remove reports.
Reports Only Access	Request and view/remove reports.
PHI Access	Information accessible when calling or emailing Allegiance.

Please list all persons who should have online access.

Recipient Name/Title (Please Print)	Phone Number	Email Address	Email Notification of Report Availability. **Must have either Full or Reports only Access to retrieve reports.*	Access Level:
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
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N: T:			☐ Automatic Reports* ☐ Funding Reports* ☐ Payroll Deduction ☐ Quarterly Reports ☐ Monthly Repay ☐ HSA Account Detail ☐ HSA Funding ☐ HSA Employer Sum	☐ Full Access* ☐ Reports Only Access* ☐ PHI Access*
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Name (Print): ___________________________________ Title: ________________________

Signature: ______________________________________ Date: ________________________

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by Cigna Healthcare

PAYROLL DEDUCTION INFORMATION

Employer Name: _____

PAYROLL ROUNDING INFORMATION			
Rounding of Payroll Deductions: *(Please indicate the rounding method for uneven deductions. Example: $1,000/elections/26 payrolls = $38.4615)*	☐ Standard Rounding	☐ Adjust First Period	☐ Adjust Last Period
	☐ Round Up	☐ Adjust First Period	☐ Adjust Last Period
	☐ Round Down	☐ Adjust First Period	☐ Adjust Last Period

Payroll Name: (Example: BW or BW26)	
Benefits Deduction Payroll Cycle: (Please select your payroll cycle for withholding deductions.)	☐ Weekly (52 pay periods/year) ☐ Bi-Weekly (24 pay periods/year) ☐ Bi-Weekly (26 pay periods/year) ☐ Semi-Monthly ☐ Monthly

Please complete the specific payroll benefit deduction dates in the calendar below:

20_____		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Pay Dates	1st												
	2nd												
	3rd												
	4th												
	5th												

Payroll Name: (Example: BW or BW26)	
Benefits Deduction Payroll Cycle: (Please select your payroll cycle for withholding deductions.)	☐ Weekly (52 pay periods/year) ☐ Bi-Weekly (24 pay periods/year) ☐ Bi-Weekly (26 pay periods/year) ☐ Semi-Monthly ☐ Monthly

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Pay Dates	1st												
	2nd												
	3rd												
	4th												
	5th												