PREMIUM ONLY PLAN APPLICATION

SECTION A: GENERAL PLAN INFORMATION

1. Plan Sponsor (Employer's complete legal name) ("Client") ______________________________

2. Business type ◯ Corporation ◯ S-Corp. ◯ Sole Proprietor ◯ Partnership ◯ LLC ◯ Not-for-Profit ◯ Government ◯ Religious

3. Federal Employer Identification Number (must be nine digits.) ________ — ________________

4. Employer's principal office: This Premium Only Plan shall be governed under the laws of the ◯ State ◯ Commonwealth ______________

5. Legal name(s) of affiliated company(ies) that will be covered by this Plan

____

6. Effective date of the Plan (check one)

a. ◯ A new Section 125 Premium Only Plan effective as of (date) ____________

b. ◯ An amendment and restatement of an existing Section 125 Plan (transfer of Premium Only Plan from your current administrator)

(1) Effective date of original plan ____________ (2) Effective date of amended and restated plan ____________

The effective date of a new or restated plan should be the beginning of the first payroll period for which employee contributions will be made on a pre-tax basis. It is not necessary for the effective date to coincide with the first day of the Plan Year (short Plan Years are permitted in the first Plan Year). The plan document or restatement must be signed prior to its effective date.

7. Plan year: The first plan year for this Premium Only Plan will be a (check one)

a. ◯ 12-consecutive-month period beginning (date) ____________ and ending (date) ____________

b. ◯ Short plan year beginning (date) ____________ and ending (date) ____________

The Plan Year usually coincides with the renewal date of the insurance plan, calendar year or company fiscal year.

8. Benefits: All benefits listed below may be included in the Premium Only Plan, whether you currently offer them or not.

- Health Insurance premiums, including major medical, accident, cancer and critical illness, dental, vision, and hospital indemnity. However, insurance products with a return-of-premium feature cannot be deducted on a pre-tax basis.
- Group-term life insurance (only the first $50,000 including employer-provided coverage, can be pre-tax)
- Health Savings Accounts contributions that are made through payroll deduction
- Disability insurance (pre-tax premium or benefit, but not both)

9. Total number of employees ____________

SECTION B: ADMINISTRATOR

(Indicate the name and address of the person within the company responsible for plan administration. The application should be signed by an authorized representative of the company. Reminder: Please do not start pre-tax deductions until you have received the Administrative Kit and signed the Plan Document from HealthEquity.)

Plan administrative contact ______________________ Title ______________________

Mailing address ____

City, State, Zip ____

Phone ______________ Fax ______________ Email ______________________

HealthEquity will be the plan service provider, but will not be the Plan Sponsor or Plan Administrator. This Agreement will become effective on the "Effective Date of the Plan." It will continue for an initial term of one year beginning with the Effective Date, or the Amendment and Restatement Date, and continue thereafter for successive one-year terms ("Renewal Terms") or until terminated by either party upon 90 days prior written notice. **The one-time non-refundable Implementation Fee must be enclosed with this Application.** For each Renewal Term, Client agrees to pay an Annual Compliance Service Fee billed at the end of each Plan Year.

Implementation Fee $ ____________ (call for a quote)

Annual Compliance Fee (billed at the end of each Plan Year) $ ____________ (call for a quote)

Client signature ______________________________ Date ____________

This Application and Implementation payment must be received by HealthEquity at least 15 business days prior to the Effective Date.

◯ Check enclosed for $ ____________ (payable to HealthEquity, PO Box 870725, Kansas City, MO 64187-0725)

◯ Charge my credit card for $ ____________ ◯ VISA ◯ MC ◯ AMEX ◯ Discover Expiration date ____________

Credit card number ______________________ Name on card ______________________

SECTION C: REFERRAL SOURCE/BROKER OF RECORD

Name of referral source ______________________ Affiliated company ______________________

Address (No PO boxes) ____

City, State, Zip ____

Phone ______________ Fax ______________ Email ______________________

The referring company or its representative may earn a fee for services performed in connection with the implementation of this plan.

Scan and email this completed form to pophelp@healthequity.com or FAX to 877-769-0173 Questions? Call 800-876-7548 (Weekdays, 8 a.m. – 5 p.m. Central)

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