FURTHER SM

VEBA DIRECT PLAN DESIGN GUIDE

Please complete this form and return to Further 45 days before your effective date so we can properly administer your plan. If you have any questions, please call our Sales Line at 855-363-2583. When complete, fax this form to 1-866-231-0214; mail it to Further, PO Box 982814, El Paso, TX 79998-2814; or email it to Further.Sales.Support@HelloFurther.com.
All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Legal Name_____

Employer's Street Address_____

City_____ State _____ ZIP Code _____

Employer's Tax I.D. Number _____

Number of employees eligible (not enrolled) for plan: _____

Primary Contact Person:
(This person has access to all plan information and can add, edit, or remove portal access for additional contacts)

Primary Contact Person _____ Title _____

Phone Number ( ) _____

Email Address _____

Additional Contact Person:
(This person has access to all plan information and edit access for group portal.)

Additional Contact Person _____ Title _____

Phone Number ( ) _____

Email Address _____

Additional Contact Email Notifications

☐ Fee Billing

II. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health Plan Carrier _____

☐ Start Date: _____ ☐ End Date: _____

III. AGENCY/BROKERAGE INFORMATION

Agency Name: _____ Agency Code: _____

Agent Name: _____ Agent Code: _____

Agency Contact Name *(if different than agent)*: _____

Email: _____ Phone: _____

Address: _____

IV. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another Trust? ☐ Yes ☐ No

If you've answered "yes", indicate the date the Trust was established _____

Trust Legal Name _____

Trust Tax ID Number _____

☐ Was trust established prior to 01/01/2008?

☐ If "yes", did your trust allow members to list beneficiaries?

V. ACCOUNT ADMINISTRATIVE INFORMATION

Plan Start Date _____ Plan End Date _____

Eligibility **(***Required for Plan documents. This (generally matches that of the health plan.)*

Employees must work at least _____ hours per week to be eligible

Benefits will begin on: (select **only** one):

☐ First of the month following date of hire

☐ Date of hire

☐ First *day* after completion of the waiting period

☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

☐ First of the *month* after completion of the waiting period

☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

Plan Features

Select one or more of the following features:

☐ Post-retirement Health Care Savings Arrangement (amounts payable after employee's retirement from public employment). If this feature is chosen, select all that apply below:

☐ Accounts funded with accrued severance pay, vacation pay, sick pay or similar amounts following termination of employment

☐ Accounts funded over employee's working life for use in retirement

☐ Health Reimbursement Arrangement for Active Employees

VI. ADMINISTRATIVE FEES

Fee's will be billed on a monthly basis. If participant paid, the monthly fee will be taken from the participant's account balance.

Participant Fees for active employees:

☐ Employer Paid

☐ Participant Paid

You will receive an automated e-mail notification when your detailed billing information is available and another email notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign in to the Online Group Service Center to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information (completion of this section is mandatory)

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **administrative fees.** The following bank account information is provided to Further for initiation of this procedure.

Bank Name _____

Type of Account: ☐ Checking ☐ Savings

Bank ABA Number _____
(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip.)

Bank Account Number_____
(Funds will be drawn from your bank account on or after the 20th of each month.)

VII. REIMBURSEMENT

Reimbursement

- Employees use the debit card to pay for expenses just as they would use a bank debit card. All participants will be issued one debit card. A debit card for dependents may be requested online.

Copay Amounts

The copay amounts provided below will allow members to auto substantiate when the debit card is used. Documentation will not be required for reimbursement.

Please indicate the health plan copay amounts below. If you have more copays that what is listed below, please complete the Group Copay Form. Amounts must be indicated on the PDG or the Group Copay Form, otherwise the copay amounts will not be added.

Medical: _____ Vision: _____ Drug: _____

VIII. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

☐ Group Online Service Center. (The employer will enroll participants online using the Group Online Service Center at **hellofurther.com.)**

(Employer will enroll participants using a secure file transfer process.)

IX. DEDUCTION/CONTRIBUTION INFORMATION

It is required that you submit contribution information via Secure File Transfer.

Please note that account funding must be initiated by you through the standard electronic file format before each ACH transaction can occur.

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **VEBA contributions**. The following bank account information is provided to Further for initiation of this procedure.

Bank Name _____ Type of Account: ☐ Checking ☐ Savings

Bank ABA Number _____
(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

Bank Account Number _____

X. ADMINISTRATIVE TIPS

ONLINE ACCESS: hellofurther.com

With Further, your employees have access to a powerful tool for managing their VEBA. By registering with hellofurther.com, your employees can:

- Enroll in direct deposit
- View recent claims or reimbursement requests
- Create and view a customized statement
- Manage their personal profile

You can also access forms and enrollment materials at **hellofurther.com.**

LOCATIONS: Multiple Further locations are available for 51+ groups only. If you want multiple Further locations, please complete and attach the Location Addendum (F8928). Locations must be the same across all products administered by Further. If you wish to have different ACH accounts by location, please complete the Group ACH Form (X9055).

COORDINATING WITH AN HSA: For participants that have a VEBA and a HSA, the VEBA provides reimbursement for permitted benefits such as vision and dental care benefits until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses, excluding deductible expenses, are eligible for reimbursement.

This affects only those participants who are eligible to contribute to their HSA. Participants who are not eligible to contribute to an HSA will have a full VEBA.

Please note: If the HSA is not administered by Further or the health plan is not with Blue Cross and Blue Shield of Minnesota, the group is required to manually notify Further which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (F8978) to Further to indicate that the deductible has been satisfied prior to receiving reimbursement for 213(d) eligible expenses.

PRIMACY INFORMATION: If you are also offering an FSA administered by Further, eligible expenses will be reimbursed from the Medical FSA until a participant's account is exhausted. Only then will eligible expenses be reimbursed from the participant's VEBA Account for Active Employees.

XI. SIGNATURES

It is agreed that necessary information concerning current and future employees and/or their dependents who participate in this Plan and employees whose participation is to be changed or discontinued, shall be provided to Further on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signature _____ Date _____

Printed Name _____ Title _____

XII. IN OFFICE USE:

Distribution/Channel Partner _____

Market Segment _____