



Request/Authorization for Integrated Billing Arrangement

As an added service to you, we offer the option of integrated billing for both your insurance premium and HSA contributions. If you choose to establish your employee HSAs through our preferred banking partner, HSA Bank, we can offer you the following:

- **Reduced account setup fees.** We have negotiated a discounted setup fee of \$16 per account for our integrated billing clients (versus HSA Bank's standard fee of \$25 per account).
- **Streamlined enrollment.** We will facilitate both the health insurance enrollment and the banking setup in a single step.
- **One-stop convenience.** You'll only need to have one point of contact – PacificSource – for both pieces of your benefit solution.
- **Automatic electronic payment.** There are no checks to write since we'll automatically debit your account each month for both the insurance premium and the HSA contributions.

Requirements

To participate in our integrated billing service:

- You agree to collect and pass on to us any ongoing, scheduled HSA contributions. HSA contributions may be paid by you on behalf of your employees, or by your employees through you via payroll deduction (either pre-tax or after tax). You will also provide us with the information needed by our banking partner to credit those HSA contributions to the correct employee accounts. We will provide the forms needed to do this.
- You agree to provide your insurance premium payments and HSA contributions to us via electronic funds transfer (EFT).
- You agree to provide your first month's premium payment and HSA contribution by check. EFT payments can then begin on the second month of coverage, provided we receive all necessary forms and information no later than 10 days prior to the payment due date.
- For the initial month, HSA Bank requires a one-time \$16 setup fee per account. The ongoing monthly HSA contributions for each employee can be set at any amount. The enrollment form you complete and provide to us will allow you to specify both an initial contribution, and an ongoing contribution for each account.
- You understand that once money is deposited into an HSA, it becomes the property of the account holder and cannot be recovered. Therefore, retroactive changes to HSA contributions are not possible.
- Employees may change their HSA contribution elections prospectively by notifying you. You may then notify us of the change along with any other billing adjustments for the coming month. (See "Your Responsibilities" below for notification deadlines.)
- If employees wish to make additional HSA contributions outside of this automated arrangement, they may do so by contacting HSA Bank directly.
- You agree to provide us with an email address and fax number for notification of billing amounts.

Our responsibilities:

- We will mail you a billing statement including your insurance premium and your HSA contributions by the 18th of the month prior to the month being billed.
- We will adjust your bill for any enrollment or contribution changes or corrections received by the 25th day of the prior month.
- On the last business day of the month, we will notify you via email and fax of the amount to be debited from your bank account.
- On the first business day of each month, we will debit your designated bank account via electronic funds transfer (EFT) for the full amount due for insurance premium and HSA contributions, as indicated in the above notice.

- By the sixth business day of each month, we will transmit your HSA contributions to HSA Bank via EFT or wire transfer, along with a file detailing the distribution of funds by account holder. HSA Bank may hold the funds for 4 business days and then deposit the appropriate funds to each participant's account.

Your responsibilities:

- You will provide us with the information and permissions we need to establish ongoing, scheduled EFT transactions from your designated bank account.
- You will provide us with any HSA enrollment or contribution changes, in writing, as early as possible, but no later than the 25th day of the month prior to the effective date of the change.
- You will ensure that your designated bank account contains sufficient funds to allow the EFT transaction to take place on the first business day of each month. See "Insufficient Funds" below for more information.
- If you allow pre-tax HSA contributions via payroll deduction, you are responsible for maintaining an IRS-compliant Section 125 plan that allows HSA contributions. For help with this, please contact your Section 125 plan administrator, a CPA, or a tax attorney.*
- If you also offer a health flexible spending plan (health FSA) or HRA, you are responsible for ensuring that your plan documents are compliant with rules that regulate how FSAs, HRAs, and HSAs may co-exist as part of a benefit package. For help with this, please contact your FSA administrator, a CPA, or a tax attorney.*
- You and your employees understand that, should you fail to make any HSA contributions on your employees' behalf, PacificSource will not be liable for any losses, damages, costs, penalties, or expenses incurred as a result. It is your responsibility to collect and pass to us any employee HSA contributions; we will then ensure that those contributions are deposited to the correct accounts with HSA Bank. We are not responsible for monitoring your contributions to employees' HSAs or for notifying employees of your contributions. Employees should contact you with questions about contributions made on their behalf.

Insufficient Funds

If we attempt to debit your bank account on the designated day and the account's funds are insufficient, the transaction will not be completed. We will contact you by phone to discuss the situation and agree on a date when the transaction will be reattempted. We will assess a fee of \$50 each time we attempt to debit your account and there are insufficient funds to complete the transaction.

If payment is impeded by insufficient funds twice in any 12-month period, we will terminate this integrated billing arrangement. In that case, we will put you in touch with our HSA trustee and you may arrange for HSA contributions directly with them. We will then resume monthly billing for your insurance premium only.

Employer Name

Employer Address

Name of Authorized Employer Representative

Title

Signature

Date

* *PacificSource does not administer Section 125 plans, but our subsidiary, **Manley Services**, does. If you are in need of a Section 125 plan administrator, you are welcome to contact the Manley Services sales department at 800-422-7038.*

HSA Employer Contribution Form



PO Box 7068 • Eugene, OR 97401
 (541) 686-1242 • (800) 624-6052
 Membership Fax (541) 683-8328
 Marketing Fax (541) 485-0915
www.pacificsource.com

EMPLOYER INFORMATION

Employer: _____ Group Number (if known): _____

Is your business an S Corp? No Yes (If yes, please list owners): _____

Business Street Address: _____

City: _____ State _____ ZIP Code: _____

Phone (required): (_____) _____ Fax (required): (_____) _____

E-Mail Address (required): _____ Contact Person: _____

If you, the employer, will contribute funds toward your employees' HSAs, please indicate the amounts you will contribute for each family category (even though you may not currently have employees in each category).

Family Categories	Monthly Contribution*
Employee Only (EO)	\$ _____
Employee + Spouse (ES)	\$ _____
Employee + Family (EF)	\$ _____
Employee + Children (EC)	\$ _____

*These amounts must match your monthly contribution amounts listed on the next page.

EMPLOYEE INFORMATION

If you maintain a cafeteria plan under Section 125 of the Internal Revenue Service Code, you may permit employee contributions to be made through the cafeteria plan on a pre-tax basis. If you do not maintain a cafeteria plan (or do not choose to permit contributions through a cafeteria plan), your employees may make contributions via payroll deduction on an after-tax basis.

On the attached forms, please list all employees for whom an HSA will be created. *If additional space is needed, please complete and attach a supplement to this form (available on our Web site at www.pacificsource.com).*

DISCLOSURE

PacificSource will not be liable to the employee for any losses, damages, costs, penalties, or expenses incurred as a result of the employer's failure to make contributions to the employee's HSA. PacificSource is not responsible for monitoring the employer contributions to the employee's HSA or notifying the employee of the employer's contributions. The employee is responsible for contacting the employer regarding contributions and monitoring those contributions. It is the employer's responsibility to confirm that employees are eligible to participate in the HSA.

HSA CONTRIBUTIONS

In the table below, please list all employees for whom an HSA account will be created. In the far right columns, enter the initial and monthly HSA contributions. **Please note:**

- Employer contribution amounts *within a family category* **must match** (for example, if one employee in the EO category receives \$40, all other employees in that category must also receive \$40).
- Employer contribution amounts *in different family categories* **may differ** (for example, all employees in the EO category may all receive \$40 and all employees in the ES category may receive \$60).
- Your initial HSA contribution may be greater or lesser than the ongoing monthly contribution amount.

If additional space is needed, please complete and attach a supplement form to this form.

Employee Name	Social Security Number	Family Category				Pre-Tax		Employee Contributions		Employer Contributions	
		EO	ES	EF	EC	Yes	No	Initial	Monthly	Initial	Monthly
<i>Example: Jane Doe</i>	<i>000112222</i>	<i>X</i>				<i>X</i>		<i>\$25.00</i>	<i>\$25.00</i>	<i>\$40.00</i>	<i>\$40.00</i>
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17.											
18.											
19.											
20.											
A. Subtotal:											
B. Subtotal of supplement form(s), if applicable:											
Total of A + B:											
Setup Fee (Total employees x \$16):											
TOTAL HSA AMOUNT PAYABLE (Total employer and employee <i>initial</i> deposit + setup fee):											

Please make your check payable to PacificSource Health Plans

**Supplement to
HSA Contribution
Form**



PO Box 7068 • Eugene, OR 97401
(541) 686-1242 • (800) 624-6052
Membership Fax (541) 683-8328
Marketing Fax (541) 485-0915
www.pacificsource.com

Use this form as a supplement to the HSA Employer Contribution Form or your bill.

EMPLOYER INFORMATION

Employer: _____ Group Number (if known): _____

HSA CONTRIBUTIONS

Employee Name	Check One		Social Security Number	Family Category				Pre-Tax		Employee Contributions		Employer Contributions	
	Add	Delete		EO	ES	EF	EC	Yes	No	Initial	Monthly	Initial	Monthly
<i>Example: Jane Doe</i>	X		000112222	X				X		\$25.00	\$25.00	\$40.00	\$40.00
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Subtotal:													
(Please carry these subtotals over to Section B of the contribution table on the HSA Employer Contribution Form.)													

Please attach this form to the HSA Employer Contribution Form or your bill.

**Authorization Agreement
for Recurring Electronic
Fund Transfers (EFT)**



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Please note: The first month's payment cannot be made by EFT.

This form must be completed and returned at least 10 days prior to the payment due date. Until then, you must make payments by check or your account will become past due and your policy will be subject to cancellation.

EMPLOYER INFORMATION

Employer: _____
Group Number (if known): _____ Federal I.D. Number: _____
Business Street Address: _____
City: _____ Zip Code: _____ County: _____
Phone No.:(_____) _____ Fax No. (required):(_____) _____
E-Mail Address for Billing Contact Person (required): _____

BANK INFORMATION

Employer's Financial Institution: _____
Address: _____
City: _____ Zip Code: _____ County: _____
Phone No.:(_____) _____ Checking (not savings) Account No.: _____
Nine-Digit Financial Institution Routing Number (for bank use only): _____

Please attach a voided check (required).

DISCLOSURE

We authorize and direct PacificSource Health Plans to withdraw funds each month from our bank account stated above. This authorization will remain in effect until terminated by either party.

Authorized Representative of Employer (print name): _____

Signature: _____ Date: _____

Title: _____

FOR PACIFICSOURCE ADMINISTRATIVE USE ONLY

Date entered in Reflections: _____ EFT effective date: _____