IRC SECTION 132 (f)(4)
TRANSPORTATION REIMBURSEMENT PLAN CHECKLIST

ID#:

1. NAME OF EMPLOYER

_____
(Exactly as it is to appear with punctuation)

2. EMPLOYER'S ADDRESS

_____
(Physical)

_____
(PO Box)

_____
(City) (State) (Zip)

Telephone _____

Fax # _____

3. CONTACT PERSONNEL

Human Resources: _____

HR Phone: _____

HR E-Mail Address _____

Payroll Department: _____

PR Phone: _____

PR E-Mail Address _____

Person Authorized to amend Plan:

_____
(Name) (Title)

4. EMPLOYER'S TAX ID NUMBER

_____

5. PLAN YEAR

Begins _____
(Month / Day) (January 1)

Ends _____
(Month / Day) (December 31)

Is first year a short Plan Year?

☐ Yes, beginning _____
(Month / Day) (May 1)

☐ N/A

6. EFFECTIVE DATE(S)

Initial effective date _____
(Month / Day / Year) (1/1/2022)

This restatement _____
(Month / Day / Year) (1/1/2022)

7. ELIGIBLE CLASS OF EMPLOYEES

☐ All Employees.
☐ Other: _____

8. CONDITIONS FOR ELIGIBILITY

☐ Date of Hire
☐ Other _____

9. CONTRIBUTIONS. Plan will provide for

☐ Salary reduction contributions ONLY (No Employer contribution)
☐ Employer contributions ONLY (No salary reductions)
☐ Both salary reductions AND Employer contributions
☐ After tax contributions: $_____ maximum.

10. QUALIFIED BENEFITS (May be elected for)

☐ Transportation
  ☐ Pre-Tax Contributions
  ☐ Post-Tax Contributions

☐ Parking
  ☐ Pre-Tax Contributions
  ☐ Post-Tax Contributions

11. ELECTION CHANGE FREQUENCY

☐ Quarterly
☐ Semi-Annually
☐ Annually
☐ Monthly

12. LIST ANY ADDITIONAL COMPANIES THAT MAY BE COVERED UNDER THIS PLAN:

_____
(Company Name)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Tax ID Number)
(**NOTE:** Please attach additional affiliated Employer information)

13. LIST ANY SEPARATE DIVISIONS WITHIN THIS COMPANY:

_____
(Company Name)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Tax ID Number)
(**NOTE:** Please attach additional affiliated Employer information)

14. CLAIMS FOR REIMBURSEMENT MUST BE FILED WITHIN

☐ 60 days following each Plan Year or Termination Date.
☐ 90 days following each Plan Year or Termination Date.
☐ 120 days following each Plan Year or Termination Date.

*If you have a Flex Plan with Allegiance, your runout periods will be the same.

15. PAY CYCLE

☐ Weekly (52)
☐ Bi-Weekly (26)
☐ Semi-monthly (24)
☐ Monthly (12)

Prior to each payroll, we plan to:

☐ Load a payroll contribution file. We don't need a payroll deduction notification.

☐ Auto post each pay period, Receive the payroll deduction notification seven business days prior to our scheduled payroll date. We will make any corrections needed within four business days of the notification.

Please attach a payroll calendar.

16. OPEN ENROLLMENT OPTIONS

☐ Online enrollment.
☐ Enrollment through employer and send a file.

17. BROKER NAME & ADDRESS

_____
(Name)

_____
(Company)

_____
(Address)

_____
(City) (State) (Zip)

E-mail Address _____

Telephone: _____

Fax: _____

Federal Tax ID# _____

18. FEES

	FEES	
Initial Set-Up Fee	$_____	
Fee for Participant/Month	$_____	☐ E-Price
Minimum Monthly Fee	$_____	

19. DELIVERY OF INDIVIDUAL PARTICIPANT WELCOME PACKETS (Select method)

☐ Mail to participants individually at $2.00 per packet.
☐ Email all enrollment confirmation materials to the employees.

20. HOW DO YOU WANT TO FUND YOUR PLAN?

☐ Allegiance withdraws funds based on claims experience electronically by ACH.
☐ Reimbursements made directly from employer bank account.

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 May 2023)

CORPORATE HEADQUARTERS
PO Box 4346
Missoula, MT 59806
(406) 721-2222 or (877) 424-3570
Fax (406) 523-3149 or (877) 424-3539
www.askallegiance.com

OREGON OFFICE
PO Box 2930
Tualatin, OR 97062
(503) 885-1888
Fax (503) 885-1988

Allegiance℠
a Cigna Company

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

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												

DEBIT AUTHORIZATION FOR CLAIMS BASED FUNDING

Allegiance® a Cigna Company

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 and/or bank letter to confirm banking information noted above.

Confirmed date that Claims Based Funding should start _____

Claims payments releasing daily.

2806 Garfield, P.O. Box 4346, Missoula, MT 59806-4346
Phone: 877.424.3570 | Fax: 877.424.3539 | www.askallegiance.com

DEBIT CARD IMPLEMENTATION AGREEMENT

This notice is confirmation that _____has elected to implement the debit card option for our reimbursement accounts as of _____. As sponsor/plan administrator of the plan, we understand:

- Successful implementation and efficient administration is directly related to employer understanding and support of the process, clear and appropriate employee communications, and timely submission of plan year enrollment.

- Each participant will receive two cards; the second card may be signed and used by the spouse or dependent at the discretion of the participant.

- Plan participants will now have two reimbursement options: traditional claim filing and the debit card. IRS regulations require claims may need to be substantiated.

- Participants will receive a cardholder agreement. Employees will certify, upon enrollment and through each use of the card, that they will use the card only for eligible expenses, that any expense paid by the card has not been reimbursed nor will the employee seek reimbursement under any other plan. Participants will retain documentation for all expenses for submission to claims processor.

- Cards will be inactivated if a plan participant does not provide appropriate documentation when requested and the participant will be required to reimburse the plan. Unsubstantiated claims not reimbursed by a participant will be charged to the employer as an expense which is offset by the gain realized when the reimbursement is removed from the plan during year-end plan reconciliation.

- Employer will have sufficient funds available at all times to cover card transactions.

- Employer will inform terminated employees that the card will be de-activated. The employer is encouraged to collect the card as part of the exit interview.

SIGNED: _____ PRINTED NAME: _____

DATE: _____ TITLE: _____

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ALLEGIANCE ADVANTAGE

Reimbursement Accounts Employer Access Form

Employer Name ____

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.

Please list all persons who should have online access.

Recipient Name./Title (Please print)	Phone Number	Email Address	Email Notification for generated reports	Access Level:
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only**
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only**
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only**
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only**
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only**
			☐ Account Invoice ☐ Employer Funding ☐ Payroll Deduction	☐ Full Access* ☐ Reports Only**

*Full Access- Manage individual employee data on employer dashboard, importing/viewing new files, view plans, request reports, view/remove reports.
**Reports Only- Request and view/remove reports.

Name (Print): ______________________________ Title: ______________________________

Signature: ______________________________ Date: ______________________________