

Intent to Enroll

This completed form must be received at least 30 days prior to requested effective date for the Pretax HSA, HFSA, LHFSA and DCAP Plan, and at least 15 days prior for the POP, Post Tax HSA and Pretax HSA Documents/Testing Only. This form should not be used for POP-only or HCSO HRA.



| Company Information | | | |
|--|---|--------------|------|
| Company Name: | | EIN/Tax ID#: | |
| Address: | City: | State: | Zip: |
| Mailing Address (if different): | City: | State: | Zip: |
| Administrative Contact: | | Phone: | Fax: |
| Title: | E-mail: | | |
| Executive Contact: | | Phone: | Fax: |
| Title: | E-mail: | | |
| Total # of Benefit Eligible Employees: | Which type of enrollment kit would you prefer (choose one): <input type="checkbox"/> CD-ROM <input type="checkbox"/> E-mail <input type="checkbox"/> Paper (\$2 each kit after the first 10) | | |

| | <u>Desired Effective Date</u> | <u>Setup Fees*</u> | | | | | | |
|--|---|---|---------------------------------|-----------------------------------|---|---------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Post Tax Health Savings Account (HSA); \$25/participant | _____ | \$ _____ | | | | | | |
| <input type="checkbox"/> Pretax HSA Documents/Testing Only; \$300 | _____ | \$ _____ | | | | | | |
| <input type="checkbox"/> Pretax Plans (check all that apply); \$500 | _____ | \$ _____ | | | | | | |
| <input type="checkbox"/> Pretax Health Savings Account (HSA); +\$25/participant | _____ | \$ _____ | | | | | | |
| <input type="checkbox"/> Premium Only Plan (POP) | | | | | | | | |
| <input type="checkbox"/> Health Flexible Spending Account (HFSA) | | | | | | | | |
| <input type="checkbox"/> Limited Health Flexible Spending Account (LHFSA) | | | | | | | | |
| <input type="checkbox"/> Dependent Care Assistance Program (DCAP) | | | | | | | | |
| <table border="1" style="width: 100%;"> <tr> <td>Enrollment kits should be mailed to (choose one):</td> <td><input type="checkbox"/> Broker</td> <td><input type="checkbox"/> Employer</td> </tr> <tr> <td>For enrollment information, contact (choose one):</td> <td><input type="checkbox"/> Broker</td> <td><input type="checkbox"/> Employer</td> </tr> </table> | | Enrollment kits should be mailed to (choose one): | <input type="checkbox"/> Broker | <input type="checkbox"/> Employer | For enrollment information, contact (choose one): | <input type="checkbox"/> Broker | <input type="checkbox"/> Employer | |
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| | Discount/Promotions <small>(if applicable)</small> | \$ - _____ | | | | | | |
| | Expedited Processing <small>(additional 25% of setup fees*)</small> | \$ + _____ | | | | | | |
| | Additional Paper Kits <small>(\$2 each after first 10 kits)</small> | \$ + _____ | | | | | | |
| TOTAL FEES PAYABLE TO COPOWER | | \$ _____ | | | | | | |

AUTHORIZATION: This is to acknowledge that our organization has reviewed and understands the information and pricing as outlined in the proposal provided. I understand that should I withdraw or cancel this Intent to Enroll after three (3) business days of signing, CoPower may retain 50% of the fees due. We will be responsible for the initial fees and for all fees to continue services in subsequent plan years. I authorize the release of information to my broker listed below as it pertains to my company's cafeteria plan.

| | | | |
|--------------------------------|---------------------------|---------|--|
| Authorized Employer Signature: | | Date: | |
| Print Employer Name: | Title: | | |
| Broker Name: | LISI Representative Name: | | |
| Broker Address: | | | |
| City: | State: | Zip: | |
| Phone: | Fax: | E-mail: | |

* See fee schedule. Does not include monthly fees per enrollee. Monthly fees are based on the number of enrollees and the number of plans selected.

Submit to: LISI San Mateo, Sacramento, Fresno, Los Angeles, Orange or San Diego. 866.570.LISI (5474)

For Office Use Only. NBS Name: _____ **Subsidy Amount:** _____ **Check Amount:** _____ **Date:** _____