

# Request for Proposal Flex Products

Please complete this form if you would like csONE Benefit Solutions to provide you with a FSA, HRA or PCP quote.

## Employer & Producer Data:

Employer Name & Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Producer Name & Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employer Contact Name: \_\_\_\_\_

Producer Contact Name: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Employer Type:     S Corp     C Corp     LLC     Sole Prop.     Partnership     Non-profit

Who would you like us to email the proposal to: \_\_\_\_\_

## Type of Proposal Requested:

Type(s) of plan(s) the employer is interested in.

- Premium Conversion Plan (PCP) Only
- Flexible Spending Plan (FSA) Includes Health FSA & Dependent Care FSA and Premium Conversion Plan
- Health Reimbursement Account (HRA)

Please check the plans the employer already has in place. If the plan(s) requested will be new, please check "none".

- Premium Conversion Plan (PCP) Only
- Flexible Spending Plan (FSA)
- Health Reimbursement Account (HRA)
- None

## Plan Details:

Plan Requested Effective Date: \_\_\_\_\_

To assure that the plan document will be completed prior to the plan effective date, all documents must be completed in their entirety and received 15 days prior to effective date to Combined Services LLC.

Eligible Employees: \_\_\_\_\_

Does the employer wish to have a Grace Period included in the Plan?     Yes     No    (FSA only)

Does the employer wish to have debit cards included in the Plan?     Yes     No    (FSA & HRA plans only)

## Send Request to:

**csONE Benefit Solutions**  
PO Box 1320  
Concord, NH 03302-1320

E-mail: marketingadmin@csONE.com

Fax: 1 603 224-4256

Phone: 1 603 227-2000

\_\_\_\_\_  
**Form Completed By**

\_\_\_\_\_  
**Date**