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### Set Up Information

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, St, Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Contact E Mail \_\_\_\_\_  
Tax I D # \_\_\_\_\_

### Plan Type

Premium Only \_\_\_\_\_ Un-reimbursed Medical \_\_\_\_\_ Dependent Care \_\_\_\_\_  
Maximum FSA Election per year \$ \_\_\_\_\_  
Plan Year \_\_\_\_\_ Run off period \_\_\_\_\_

### Funding

Claims reimbursed as received \_\_\_\_\_ this requires a 1/12<sup>th</sup> deposit of FSA election amounts  
Claims reimbursed Weekly \_\_\_\_\_ Bi weekly \_\_\_\_\_ Monthly \_\_\_\_\_  
Upon receipt of check register mail check \_\_\_\_\_ ACH funds \_\_\_\_\_  
Name of bank \_\_\_\_\_ Name of Account \_\_\_\_\_  
ABA routing # \_\_\_\_\_ Account # \_\_\_\_\_