PLAN REQUEST FORM

A Client Account Information

5,221
Total Number of Employees on Current Year Insurance

33-DCFSA/784-FSA
Total Number of Employees on Prior Year Benefit Plan

Denton Independent School District
Employer Legal Name

1307 North Locust Street, Denton, TX 76201
Employer Physical Street Address | City | State | Zip Code

75-6001311
Employer Tax ID Number (EIN)

940-369-0023
Employer Phone Number

-
Fax Number

611110
NAICS Code

Chris Bomberger
Employer Authorized Signer

cbomberger@dentonisd.org
Authorized Signer Email Address

940-369-0272
Authorized Signer Direct Phone Number

[Group Plan Admin Contact]
Employer Plan Operation Contact Person

[Plan Admin Email
Plan Operation Contact Email Address

[Plan Admin Phone]
Plan Contact Direct Phone Number

Employer Entity Type:

☐ S-Corporation ☐ C-Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Government ☐ Non-Profit Organization ☐ Limited Liability Company

☑ Public School District ☐ Church *(or church related)* ☐ University/Community College ☐ Single Public School District ☐ 501(c)(3) Organization

(Owners with more than 2% ownership may only participate in the FSA if the Employer type is a C-Corporation)

Is this group a part of a Co-Op? ◉ No ○ Yes If yes:
○ WTXEBC ○ ETXEBC ○ CTXEB ○ CBEBC ○ ESC 20 BC ○ ESC Region 11 BC ○ TIPSEBC

Affiliated Employer Information:

Does the Plan Have Participating Employers? ◉ No ○ Yes If Yes, are they part of a Controlled Group? ○ No ○ Yes

Please provide Affiliated Employer info below

Company Name	Company Address (if different than above)	Company Entity Type	Company EIN

B Agent/Broker Information

Higginbotham Public Sector
Agency Name

Debbie Walter-Bollinger
Implementation Contact Name

dwalter-bollinger@higginbotham.net
Implementation Contact Email Address

972-685-1223
Implementation Contact Phone Number

Debbie Walter-Bollinger
Agent Account Manager Name

dwalter-bollinger@higginbotham.net
Agent Account Manager Email Address

972-685-1223
Agent Account Manager Phone Number

Crystal LeMaster
CSR Name

clemaster@higginbotham.net
CSR Email Address

972-685-1221
CSR Phone Number

C Plan Types Requested

WELFARE	# of Employees eligible to participate	Prior TPA	COBRA	# of Employees eligible to participate	Prior TPA
☑ FSA Plan	5,221	Higg	☑ COBRA Services	5,221	Higg
☐ HSA Plan			☐ Other		
☐ HRA Plan					

NBS Contacts for questions about New Welfare Benefit and COBRA Plans:

Gary Southern
Director of Business Development
(801) 532-4000 ext 167 / (800) 274-0503
(801) 823-2294 (Fax)
GSouthern@NBSbenefits.com

Nancy Perkins
Associate Director of Business Development
(801) 532-4000 ext 634 / (800) 274-0503
(801) 823-2294 (Fax)
NancyP@NBSbenefits.com

For more information on our services, proposals and fee quotes, please contact us or visit our website.
www.NBSbenefits.com

Flexible Spending Account (FSA) Plan Document Request

1 FSA Plan Design Information

09/01/2026
Date NBS will begin Plan Administration

Do you currently have an FSA Plan? ○ No ◉ Yes, original effective date: 09/01

Plan Year Ends: ○ Dec 31st ◉ 08/31

Plan Number: *(ERISA Plan number for 5500 & Document Purposes)* ◉ 501 ○ 502 ○ _____

Takeover: Will NBS Administer the prior year Grace Period/ Run-out period? ◉ No ○ Yes

Health FSA Carryover: (*Health FSA carryover of unused funds available for the next Plan Year*) ◉ No ○ Yes **If yes, complete the following:**

○ COLA carryover *(may adjust annually)* **or** ○ $__________ *(Not to exceed COLA limit)*

AND ◉ No ○ Yes Would you like to offer a Grace period on the Dependent Care Flexible Spending Account?
If Yes, the Dependent Care Grace Period should last:
☐ 30 days ☐ 60 days ☐ 75 days ☐ _____ days *(Not to exceed 75 days)*

Grace Period Only (*No Carryover*): time given to incur additional Health and Dependent Care claims after the Plan Year End
○ No ◉ Yes, the Grace Period should last ☐ _____ days ☑ 30 days ☐ 60 days ☐ 75 days *(Not to exceed 75 days)*

Run-out Period: time given to turn in claims for services provided during the previous Plan Year. Equal to or greater than the Grace Period
☑ 60 days ☐ 90 days ☐ _____ days following the end of the Plan Year

Termination Run-Out Period: days a terminated employee has to submit claims for services If nothing is selected will default to 30 days
Health FSA - ☐ 60 days ☐ 90 days ☑ 30 days following the termination date
Dependent Care - ☐ 60 days ☐ 90 days ☑ 30 days ☑ following termination date or ☐ following the end of the plan year

2 Benefits

Pre-Tax Insurance Options:
☑ Group Medical ☑ Dental ☑ Vision ☐ Accidental Death ☐ Disability ☐ Cancer ☐ Group Term Life ☐ HSA ☐ Other (AFLAC, etc.)

Maximum Medical Limit: Amount will be pro-rated for short plan years
◉ IRS Maximum Annual (Current Year) ○ Other: $ Not to exceed what is permitted under Code Section 125(i)

Employer Contribution: ◉ No ○ Yes **If Yes, please complete the following:**
○ _____ % of compensation ○ $ ○ Discretionary ○ Other _______________
Contributions shall be made: ○ Pro-rata each pay period ○ Beginning of the Plan Year
Are Contributions convertible to cash? ○ Yes ○ No
Employer Contribution will be made to: ☐ All accounts ☐ Health FSA ☐ Health Savings Account ☐ Dependent Care FSA

Does your Company offer a Health Savings Account (HSA) ○ No ◉ Yes
If Yes, is there a **Limited Flexible Spending Account**? ◉ No ○ Yes
(*Please Note only Dental and Vision expenses are covered in the Limited FSA Account*)
And, does the Limited FSA turn to a **Full Flex FSA** once the statutory deductible is met? ○ No ○ Yes

Health Reimbursement Account (HRA): ◉ No ○ Yes
Dependent Care: ○ No ◉ Yes
COBRA Eligible: *(over 20 Employees in Prior Year)* ○ No ◉ Yes
Medical Plan Self-Insured: ◉ No ○ Yes
FMLA Eligible: *(over 50 Employees)* ○ No ◉ Yes
Up-Front Orthodontia Allowed: *(Braces paid in full up-front)* ◉ No ○ Yes
Evergreen Language ○ No ◉ Yes
Marketplace Drop Language ◉ No ○ Yes

3 Eligibility

Premium Portion of the Plan (POP & DCAP)
☐ Same as Group Medical Plan
☐ Date of Hire
☑ First day of the month coinciding with or following ____ days of employment
(***Cannot exceed 60 days***)

Flexible Spending Account(s) Portion of the Plan (FSA)
☐ Same as Group Medical Plan
☐ Date of Hire
☑ First date of the month coinciding with or following Date of Hire
☐ Following ____ days of employment
☐ First date of the month coinciding with or following ____ days of employment.
☐ Other:

4 Excluded Employees

☐ No Exclusions ☐ Leased ☐ Union ☐ Non-Resident Alien ☐ Part-time Employees (31 hours per week or more is considered full time)
A Part-time Employee is anyone who works less than ☐ 30 hours /week ☑ 20 hours/week ***(Not to exceed 30 hours per week)***

Flexible Spending Account (FSA) Plan Document Request

Higginbotham™ Public Sector

5 Payroll Information

Withholding Cycle – (Payroll Cycle) **Please include Payroll Schedule(s) with this form**

☐ Weekly (52) ☐ Every Two Weeks (24) ☐ Every Two Weeks (26) ☑ Semi-monthly (24) ☐ Monthly (10x/yr) ☑ Monthly (12x/yr)

Payroll Reporting Cycle ☑ (17)

○ Same as Withholding (preferred) ◉ Monthly

Payroll Contact Information Next Two Pay dates: [First Pay Date] [Second Pay Date]

Jennifer Spencer	(940) 369-0025	Spencer, Jennifer <jspencer@dentonisd.org>
Payroll Contact	Payroll Contact Phone Number	Payroll Contact email address

6 Type of Funding

Type of Funding: *(please select the method of payment the Employer will use to get funds to NBS)*

○ Client submitting funds and reporting to Higginbotham to route to NBS ◉ Client submitting funds and reporting directly to NBS

If Client submitting directly to NBS:

○ NBS pulls payment from the Employer Account **(Preferred Method)**

◉ Client will push NBS funds via ACH **(Funds must be received within one week after payroll date)**

○ The Employer sends funding to NBS via Check **(Check must be received within one week after payroll date)**

7 Fees

Debit Cards: All Health FSA Participants receive a card. Fee is included in Administration Fee.

NBS Administrative Fees:

Doc Fee paid by: Waived Monthly Administration Fee paid by: HPS

8 Additional Notes

(*Special provisions such as adopting employers)*

Health Savings Account (HSA) Plan Administration Request

Higginbotham™ Public Sector

1 HSA Plan Design Information

Do you currently offer an HSA Plan? ○ No ○ Yes

Date NBS will begin Plan Administration

2 Employer Contribution

☐ No ☐ Employer Match ☐ Annual Contribution in the amount of: Single $ Family $

3 Excluded Employees

☐ No Exclusions ☐ Leased ☐ Union ☐ Non-Resident Alien ☐ Part-time Employees (31 hours per week or more is considered full time)

A Part-time Employee is anyone who works less than ○ 30 hours /week ○ _____hours/week ***(Not to exceed 30 hours per week)***

4 Eligibility for HSA

☐ Same as Group Medical Plan
☐ First date of the month coinciding with or following Date of Hire
☐ First date of the month coinciding with or following days of employment.

☐ Date of Hire
☐ Following days of employment
☐ Other:

5 Other Benefits Employee may have

Cafeteria Plan ○ No ○ Yes
Does your Cafeteria Plan offer a Limited Purpose FSA? ○ No ○ Yes

Health Reimbursement Arrangement? ○ No ○ Yes
Does your HRA offer a Limited Purpose HRA? ○ No ○ Yes

6 Fees

NBS Administrative Fees:

Doc Fee paid by: __________ Monthly Administration Fee paid by: __________ **Debit Cards Included in Administration Fee**

COBRA Service Request

1 COBRA Benefit Information

09/01/2026
Date NBS will begin Administration

○ No ◉ Yes (Employer must give permission to Carrier to allow NBS to contact directly)
Will NBS communicate directly with the carrier?

*Employers must have 20 or more full-time equivalent employees in the prior calendar year to be eligible for Federal COBRA. Part-time employees are counted as a fraction. To determine the fraction, divide the number of hours the employee worked by the number of hours the employee would need to work to be considered full-time. For example, a part-time employee works 832 hours and full-time is considered 2080 hours. The part-time employee is 40% of a full-time employee.

○ No ◉ Yes
Did you have the equivalent of 20 or more full-time employees in the prior year?

◉ No ○ Yes
Are there any former Employees currently on COBRA?

◉ No ○ Yes
Are there any termed Employees that require a COBRA packet immediately?

◉ No ○ Yes
Would you like NBS to send out the COBRA initial rights notice to all current employees on health insurance?

☐ Participant must elect all benefits offered
☑ Participant may elect the individual plans
If dental and/or vision are offered in addition to health

Company Pays Premiums
◉ Through end of month of the qualifying event
○ Through date of qualifying event
○ Other: ______________________________

The 18 month COBRA coverage period begins
○ The day after an employee's qualifying event
◉ The first day of month following qualifying event
○ Other: ______________________________

Who should be notified of Enrollments/Terminations/Changes?
☐ Primary Contact ☑ Broker ☐ Carrier
☐ Other __________________

Changes will be sent in a separate email for each participant at the end of the day

Who will need access to the COBRA Employer Portal?
Primary Contact and
☑ Other: First Name Gabby Last Name Lanza
Email address: clientservice@higginbotham.net
If any additional needed, please include in Notes section below

Will Broker need online access? ◉ No ○ Yes Broker Name Gabby Lanza Broker Email clientservice@higginbotham.net

Higginbotham Clients utilize Allsynx to notify NBS of Qualifying Events and new Members of COBRA Eligible Benefit Plans

Allsynx Contact Name: Joy Jackson

Benefit #1

Who will NBS remit premiums to? ○ Employer ◉ Carrier ○ Higginbotham

☑ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement (HRA) ☐ Flexible Spending Account (FSA)
☐ On-Site Health Care Facility ☐ Employee Assistance Program (EAP) ☐ Executive Medical Reimbursement Plan

Plan Type

BCBS
Benefit Provider

Anita Howell
Eligibility/Enrollment Contact

1307 North Locust Street, Denton, TX 76201
Benefit Remittance Address, City, State, Zip Code (required if remitting to provider)

972.766.7513
Phone Number

76201
Fax Number

anita_howell@bcbstx.com
Email Address

Policy Number
(required if communicating to provider)

BCBS High Deductible Plan
Plan Name

09/01/2027
Next Renewal Date (MMDDYYYY)

Please provide Carrier Rate Table and SBC
Rate table must not include 2% COBRA Fee

EE	$ 613.96	EE + Child	$ 1,043.85	EE + Family	$ 1,971.85
EE + Spouse	$ 1,607.61	EE + Children	$ 1,043.85	Other:	$

Is there a Provider rate guarantee in effect for this benefit? ○ No ○ Yes If yes, date of rate guarantee expiration [RG Expiration]

Benefit #2

Who will NBS remit premiums to? ○ Employer ◉ Carrier ○ Higginbotham

☑ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement (HRA) ☐ Flexible Spending Account (FSA)
☐ On-Site Health Care Facility ☐ Employee Assistance Program (EAP) ☐ Executive Medical Reimbursement Plan

Plan Type

BCBS
Benefit Provider

Anita Howell
Eligibility/Enrollment Contact

COBRA Service Request

1307 North Locust Street, Denton, TX 76201
Benefit Remittance Address, City, State, Zip Code (required if remitting to provider)

972.766.7513 — Phone Number
76021 — Fax Number
anita_howell@bcbstx.com — Email Address
402259 — Policy Number (required if communicating to provider)

BCBS Platinum HMO Plan — Plan Name
09/01/2027 — Next Renewal Date (MMDDYYYY)

Please provide Carrier Rate Table and SBC
Rate table must not include 2% COBRA Fee

EE	$ 693.36	EE + Child	$ 1,178.83	EE + Family	$ 2,226.85
EE + Spouse	$ 1,815.50	EE + Children	$ 1,178.83	Other:	$

Is there a Provider rate guarantee in effect for this benefit? ○ No ○ Yes If yes, date of rate guarantee expiration [RG Expiration]

Benefit #3

Who will NBS remit premiums to? ○ Employer ◉ Carrier ○ Higginbotham

☑ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement (HRA) ☐ Flexible Spending Account (FSA)
☐ On-Site Health Care Facility ☐ Employee Assistance Program (EAP) ☐ Executive Medical Reimbursement Plan

Plan Type

BCBS — Benefit Provider
Anita Howell — Eligibility/Enrollment Contact

1307 North Locust Street, Denton, TX 76201
Benefit Remittance Address, City, State, Zip Code (required if remitting to provider)

972.766.7513 — Phone Number
76201 — Fax Number
anita_howell@bcbstx.com — Email Address
402263 — Policy Number (required if communicating to provider)

BCBS Gold HMO Plan — Plan Name
09/01/2027 — Next Renewal Date (MMDDYYYY)

Please provide Carrier Rate Table and SBC
Rate table must not include 2% COBRA Fee

EE	$ 570.65	EE + Child	$ 970.25	EE + Family	$ 1,832.81
EE + Spouse	$ 1,494.25	EE + Children	$ 970.25	Other:	$

Is there a Provider rate guarantee in effect for this benefit? ○ No ○ Yes If yes, date of rate guarantee expiration [RG Expiration]

Benefit #4

Who will NBS remit premiums to? ○ Employer ◉ Carrier ○ Higginbotham

☐ Medical ☑ Dental ☐ Vision ☐ Health Reimbursement Arrangement (HRA) ☐ Flexible Spending Account (FSA)
☐ On-Site Health Care Facility ☐ Employee Assistance Program (EAP) ☐ Executive Medical Reimbursement Plan

Plan Type

Cigna Dental — Benefit Provider
Ruben Para — Eligibility/Enrollment Contact

1307 North Locust Street, Denton, TX 76201
Benefit Remittance Address, City, State, Zip Code (required if remitting to provider)

972-863-5152 — Phone Number
Fax Number
Ruben.Parra@CignaHealthcare.com — Email Address
Policy Number (required if communicating to provider)

Cigna High Dental Plan — Plan Name
09/01/2027 — Next Renewal Date (MMDDYYYY)

Please provide Carrier Rate Table and SBC
Rate table must not include 2% COBRA Fee

EE	$ 58.63	EE + Child	$ 113.51	EE + Family	$ 211.55
EE + Spouse	$ 125.26	EE + Children	$ 113.51	Other:	$

Is there a Provider rate guarantee in effect for this benefit? ○ No ◉ Yes If yes, date of rate guarantee expiration 8/31/2027 with rate cap year two

NBS Administration Fees

Set-up fee paid by: Waived   Monthly Administration fee paid by: HPS

Notes: Also FSA with NBS

COBRA Administration Request – Additional Benefits

Employer Legal Name

Benefit #4

NBS will remit payment to:______________________ ☐ No ☐ Yes

☐ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement ☐ Flexible Spending Account
☐ On-Site Health Care Facility ☐ Employee Assistance Program ☐ Executive Medical Reimbursement Plan

Plan Type

Benefit Provider | Eligibility/Enrollment Contact

Address, City, State, Zip Code

Phone Number | Fax Number | Email Address | Policy Number

Plan Name | ☐ Yes ☐ No Conversion Available | Renewal Date

Supply Rate Sheet or Fill In Below:

Single	$	Family	$	Employee + Children	$
Two Party	$	Employee + Child	$	Other:	$

Benefit #5

NBS will remit payment to:______________________ ☐ No ☐ Yes

☐ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement ☐ Flexible Spending Account
☐ On-Site Health Care Facility ☐ Employee Assistance Program ☐ Executive Medical Reimbursement Plan

Plan Type

Benefit Provider | Eligibility/Enrollment Contact

Address, City, State, Zip Code

Phone Number | Fax Number | Email Address | Policy Number

Plan Name | ☐ Yes ☐ No Conversion Available | Renewal Date

Supply Rate Sheet or Fill In Below:

Single	$	Family	$	Employee + Children	$
Two Party	$	Employee + Child	$	Other:	$

Benefit #6

NBS will remit payment to:______________________ ☐ No ☐ Yes

☐ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement ☐ Flexible Spending Account
☐ On-Site Health Care Facility ☐ Employee Assistance Program ☐ Executive Medical Reimbursement Plan

Plan Type

Benefit Provider | Eligibility/Enrollment Contact

Address, City, State, Zip Code

Phone Number | Fax Number | Email Address | Policy Number

Plan Name | ☐ Yes ☐ No Conversion Available | Renewal Date

Supply Rate Sheet or Fill In Below:

Single	$	Family	$	Employee + Children	$
Two Party	$	Employee + Child	$	Other:	$

P.O. Box 219893, Kansas City, MO 64121-9893 • (801) 532-4000, (800) 274-0503 • www.NBSbenefits.com

COBRA Administration Request – Additional Benefits (continued)

Employer Legal Name

Benefit #7

NBS will remit payment to:__________________ ☐ No ☐ Yes

☐ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement ☐ Flexible Spending Account
☐ On-Site Health Care Facility ☐ Employee Assistance Program ☐ Executive Medical Reimbursement Plan

Plan Type

Benefit Provider | Eligibility/Enrollment Contact

Address, City, State, Zip Code

Phone Number | Fax Number | Email Address | Policy Number

Plan Name | ☐ Yes ☐ No Conversion Available | Renewal Date

Supply Rate Sheet or Fill In Below:

Single	$	Family	$	Employee + Children	$
Two Party	$	Employee + Child	$	Other:	$

Benefit #8

NBS will remit payment to:__________________ ☐ No ☐ Yes

☐ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement ☐ Flexible Spending Account
☐ On-Site Health Care Facility ☐ Employee Assistance Program ☐ Executive Medical Reimbursement Plan

Plan Type

Benefit Provider | Eligibility/Enrollment Contact

Address, City, State, Zip Code

Phone Number | Fax Number | Email Address | Policy Number

Plan Name | ☐ Yes ☐ No Conversion Available | Renewal Date

Supply Rate Sheet or Fill In Below:

Single	$	Family	$	Employee + Children	$
Two Party	$	Employee + Child	$	Other:	$

Benefit #9

NBS will remit payment to:__________________ ☐ No ☐ Yes

☐ Medical ☐ Dental ☐ Vision ☐ Health Reimbursement Arrangement ☐ Flexible Spending Account
☐ On-Site Health Care Facility ☐ Employee Assistance Program ☐ Executive Medical Reimbursement Plan

Plan Type

Benefit Provider | Eligibility/Enrollment Contact

Address, City, State, Zip Code

Phone Number | Fax Number | Email Address | Policy Number

Plan Name | ☐ Yes ☐ No Conversion Available | Renewal Date

Supply Rate Sheet or Fill In Below:

Single	$	Family	$	Employee + Children	$
Two Party	$	Employee + Child	$	Other:	$

Please contact us or visit our website for more information on our services, proposals and fee quotes

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