ACQUISITION INTEGRATION TOOLKIT

ACQUISITION GUIDE

Benefits Acquisition Guide

What to Request, Why It Matters, and How to Use It

Acquisition Guide · Version 1.0 · November 2026

A plain-language guide for business owners, HR, benefits, finance, risk and integration teams. Use it to understand benefit obligations, employee impact and the steps needed for a dependable transition.

How to use this guide

Request information through the approved deal process. Compare documents, costs and enrollment records, then assign each open issue an owner. Confirm the plan for every benefit separately.

Closing, payroll onboarding and benefit coverage may begin on different dates.

SECTION 1

Understand the plans and people

Ask the seller for	Why it matters	How to use it
1. What benefits exist and who sponsors them? Inventory of medical, pharmacy, dental, vision, life, disability, retirement, spending accounts, voluntary and retiree benefits; sponsor, funding method, plan year and participating employers.	Benefits may sit in a parent-company, professional employer organization (PEO) or shared arrangement.	Identify what can continue, what needs replacing and which entities must approve changes.
2. Who is eligible and enrolled? Coded employee census: location, employment class, hours, service dates, eligibility, elections, tiers, waivers and dependent counts; leave and continuation populations.	Headcount and enrollment are different; overlooked groups create gaps.	Reconcile census to payroll, administrator and carrier records. Request identifiable details only when needed and permitted.

Ask the seller for	Why it matters	How to use it
3. What do the actual documents say? Plan documents, amendments, insurance policies, adoption agreements, Summary Plan Descriptions, Summaries of Benefits and Coverage, eligibility rules and material notices.	A benefit brochure may omit controlling terms or exceptions.	Compare documents to actual practice. Have advisors resolve inconsistencies before making employee commitments.

SECTION 2

Understand cost and coverage continuity

Ask the seller for	Why it matters	How to use it
4. What does the program cost? Recent 12 to 24 months of premiums, claims funding, fees, employer contributions, employee deductions, renewal quotes and unpaid balances.	The quoted premium may exclude material expenses.	Build a first-year budget, including transition, overlapping coverage and administrative costs.
5. How is health coverage funded? Fully insured, self-funded or level-funded contracts; third-party administrator and pharmacy agreements; stop-loss terms, exclusions and renewal conditions.	The party bearing claim risk and the contract period affect exposure.	Have the broker and finance team model retained risk and coverage at the transition. Stop-loss protects the sponsor subject to its terms.
6. What claims costs remain? Aggregate claims experience, unpaid claims estimates, claim lag, run-out provisions, reimbursement receivables and relevant stop-loss notices.	Claims incurred before closing may be paid afterward.	Estimate incurred-but-not-reported costs with qualified help. Allocate payment, administration and funding responsibilities.
7. When will each benefit end and begin? Benefit-by-benefit end dates, replacement effective dates, enrollment deadlines, waiting periods, service credit and carrier approvals.	Medical and other benefits may end on different dates.	Create a dated transition schedule. Confirm any approved waiting-period treatment; do not assume coverage starts at closing.
8. Will employees retain practical access to care? Provider networks, pharmacy coverage, ongoing-care transition processes and deductible or out-of-pocket credit options.	An insured employee can still face disruption or unexpected cost.	Seek written carrier or administrator decisions on credits and continuity processes. Arrange confidential help for affected employees.
9. What happens to continuation coverage? COBRA or state-continuation participants, pending elections, notices, premium status, vendors and relevant transaction provisions.	Responsibility depends on the arrangement and transaction facts.	Have counsel determine legal duties and document who sends notices, collects payments and maintains coverage. Contract allocation alone may not remove statutory duties.

Ask the seller for	Why it matters	How to use it
10. Are life, disability and leave cases protected? Life and disability contracts, active-at-work rules, evidence-of-insurability requirements, conversion and portability terms, and a restricted summary of open claims and leave cases.	Changing carriers can affect eligibility and claim administration.	Confirm coverage and claim ownership for employees absent from work. Give affected people accurate deadlines and confidential support.

SECTION 3

Review retirement, accounts and compliance

Ask the seller for	Why it matters	How to use it
11. What is the retirement-plan strategy? 401(k), pension and other retirement documents, amendments, eligibility, vesting, match, service-credit rules and provider agreements.	A transaction does not automatically terminate a plan or permit distributions.	Obtain specialist advice on continuation, merger, termination or another approach before committing. Confirm required pre-close actions.
12. Are retirement contributions and records complete? Contribution reconciliations, loans, participant balances, testing, filings, audits, corrections and outstanding employer contributions.	Missing deposits or inaccurate records can create continuing obligations.	Reconcile payroll to the recordkeeper; assign corrections, loan handling, notices and any blackout administration. Do not promise an automatic rollover.
13. What happens to spending accounts? Health Savings Account, health and dependent-care Flexible Spending Account and Health Reimbursement Arrangement terms, elections, contributions, balances and claim deadlines.	These accounts have different ownership and transition rules.	Have advisors confirm lawful transfer or run-out treatment and payroll mapping. Review other coverage that could affect HSA contribution eligibility.
14. Are there unresolved compliance obligations? Applicable filings, testing, required notices, audits, agency correspondence, claims disputes and corrective-action records, generally three years plus open older matters.	A sale does not erase defects or reporting duties.	Arrange ERISA, ACA, COBRA, tax, privacy and state-law review as applicable. Assess employer aggregation, reporting ownership and required corrections.

SECTION 4

Prepare the transition and follow-up

Ask the seller for	Why it matters	How to use it
15. Can vendors and systems support the transition? Broker, carrier, administrator and enrollment contracts; consents, termination fees, implementation dates, data specifications and access controls.	A signed deal does not create carrier enrollment or payroll connectivity.	Confirm authorized contacts, access and accepted enrollment files. Test eligibility and deductions before relying on the setup.

Ask the seller for	Why it matters	How to use it
16. Do employee promises match the approved plan? Benefit communications, offer terms, collective bargaining commitments, individual arrangements and any approved transition subsidies.	Unapproved promises or misunderstood deductions damage trust and may create exposure.	Approve accurate comparisons and explain costs, deadlines and service dates. Escalate contractual or bargaining obligations to counsel.
17. Is the final population ready for the change? Updated census, new hires, departures, dependents and status changes; enrollment exceptions, first deductions and carrier confirmations.	The population can change between diligence and closing.	Reconcile the final roster. Resolve rejected records, confirm effective coverage and publish a support and escalation process.
18. Who owns post-closing follow-up? Open issues, retained liabilities, carrier bills, funding, claim run-out, notices, participant questions and assigned deadlines.	Errors often surface in the first payroll or first claim.	Assign owners and evidence of completion. Reconcile first bills and payroll, then review progress at 30, 60 and 90 days.

WHAT TO WATCH FOR

Warning signs worth escalating

These findings do not automatically stop a transaction. Each needs a closer review, a decision and a named owner.

ESCALATE WHEN YOU SEE

- **No reliable match between payroll, enrollment and carrier records.** People or dependents may be missing or incorrectly covered.
- **Benefits supplied through a parent, PEO or shared plan without a confirmed exit arrangement.** Coverage may not continue with the acquired business.
- **Unconfirmed termination or effective dates, rejected enrollment files or reliance on verbal assurances.** Employees may face a coverage gap.
- **Self-funded claims exposure, stop-loss uncertainty or unpaid contributions.** A low monthly cost can conceal substantial obligations.
- **A retirement-plan termination or rollover promised before specialist review.** The transaction may not permit the assumed treatment.
- **Employees on leave or disability without a confirmed coverage and claim plan.** Active-at-work rules and carrier changes need individual review.
- **Missing filings, late deposits, unresolved notices or inconsistent eligibility practices.** Record the issue and obtain qualified review.
- **Sensitive data sent broadly, or advisors contacted before disclosure is authorized.** Use approved access and confidentiality controls.

MAKING THE CALL

Three decisions every acquisition team should make

Sort every material finding into one of three categories. Each needs a named owner.

Before a benefit change takes effect	Business or deal decision	After closing
Are coverage dates, eligibility, enrollment, required approvals and employee instructions confirmed?	Are retained claims, contribution obligations, subsidies, vendor fees or retirement decisions material to cost or terms?	Which lower-risk administrative improvements can be completed later without missing a legal or plan deadline?
Typical response Resolve the gap or arrange a lawful, approved interim solution before implementing the change. Escalate urgently if timing cannot be met.	**Typical response** Refer to leadership and qualified advisors; reflect the decision in terms, budget and the transition plan.	**Typical response** Record the owner, due date, interim arrangement and proof that the work was completed.

> **REMEMBER**
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> Closing approval does not confirm that coverage is active. Do not cancel an existing arrangement solely because a replacement application was submitted. Confirm the approved transition and actual effective dates.

PUT IT TO WORK

Working checklist

Mark one status for each item. Received and reviewed means the information was evaluated and an action or decision recorded, not simply received. Keep sensitive supporting records in the restricted transaction file.

Review item	Requests	Received / reviewed	Missing / follow up	Not applicable
Plan inventory and sponsors confirmed	1, 3	☐	☐	☐
Census reconciled to payroll and enrollment	2, 17	☐	☐	☐
Costs, renewals and contributions evaluated	4	☐	☐	☐
Funding, stop-loss and claims run-out assessed	5, 6	☐	☐	☐
End dates, start dates and eligibility approved	7	☐	☐	☐
Care transition and cost-credit decisions documented	8	☐	☐	☐
Continuation coverage duties assigned	9	☐	☐	☐
Life, disability and leave cases addressed	10	☐	☐	☐
Retirement strategy and provider actions approved	11	☐	☐	☐
Contributions, loans and corrections reconciled	12	☐	☐	☐
Spending-account treatment confirmed	13	☐	☐	☐
Compliance findings and deadlines assigned	14	☐	☐	☐
Vendor, enrollment and payroll setup verified	15, 17	☐	☐	☐
Employee communications and commitments approved	16	☐	☐	☐
Follow-up, funding and support owners assigned	18	☐	☐	☐

Open issues and next actions

One line for each material issue. Keep supporting evidence in the restricted transaction file.

Issue or missing item	Type*	Action or interim arrangement	Owner	Due date

*Before benefit change (B), Business or deal decision (D) or After closing (A).

Transition readiness

Readiness for the benefit transition	Sign-off
☐ Ready	Decision owner: _____
☐ Ready with open actions (list them above)	Review date: _____
☐ Not ready	Coverage dates and restrictions communicated: Yes / No
☐ More information needed	

READY TO SEND

Sample seller information request

Copy and adapt the request below. Remove items that do not fit the business, and obtain approval before contacting brokers, carriers or employees.

Subject: Employee benefits information request

As part of our acquisition planning, we are requesting the benefits information below to understand current arrangements, employee impact, expected costs and the actions needed before and after closing.

Please provide available records through [secure data room or approved channel] by [date]. If an item is unavailable or does not apply, please explain briefly. Begin with aggregate or coded information where sufficient; share identifiable employee, dependent, health or claim information only when specifically needed, authorized and lawfully permitted.

1. An inventory of all benefit plans, sponsors, participating employers, funding methods, plan years and vendors, including parent-company or PEO arrangements
2. A coded employee census with location, class, hours, service dates, eligibility, elections, coverage tiers and dependent counts; identify leave and continuation populations securely
3. Plan documents, amendments, policies, adoption agreements, summaries, eligibility rules and relevant participant notices
4. Recent 12 to 24 months of benefit costs, employee deductions, employer contributions, renewal proposals and unpaid amounts
5. Health-plan funding, administrator and pharmacy contracts, stop-loss terms, aggregate claims experience, unpaid-claim estimates and run-out arrangements
6. Benefit-by-benefit end dates, proposed replacement dates, waiting periods, service credit, enrollment deadlines and required approvals
7. Network and pharmacy changes, care-transition processes and any deductible or out-of-pocket credit arrangements
8. Continuation coverage administration and pending obligations, plus restricted summaries of open life and disability claims and leave-related coverage issues
9. Retirement documents, contribution and loan reconciliations, testing, filings, audits, corrections and any proposed transition or termination actions
10. Spending-account terms, elections, contributions, balances, claim deadlines and proposed transition treatment
11. Applicable compliance filings, notices, disputes, agency correspondence and open corrections, generally for three years plus older unresolved matters
12. Vendor consents, termination terms, system requirements, employee commitments, communication plans and an updated pre-close census and issue list

Please contact [name, title, email, phone] with any questions. Thank you for your help.

CONFIDENTIALITY

Confidentiality and permitted access should follow the transaction’s approved process. A confidentiality agreement alone does not authorize every disclosure of health or participant information.

FOLLOW THROUGH

Transition checkpoints

Use these checkpoints to confirm that the approved plan is working once the change takes effect.

Checkpoint	Confirm
Before the change	Approved dates for each benefit; required plan actions and consents; correct enrollment and payroll setup; notices; confidential support; responsibility for legacy obligations.
First payroll and first carrier bill	Compare elections, employee deductions, employer contributions, effective enrollment, invoices and funding. Resolve mismatches and confirm contributions reached the correct provider.
30, 60 and 90 day reviews	Close enrollment exceptions; monitor claims access and run-out; reconcile retirement and spending accounts; complete corrections and filings; confirm that employee questions have owners.

FURTHER READING

Official reference points

Use current requirements and plan terms for the actual transaction. The references below support specialist review; this guide does not prescribe universal legal deadlines or assume that every rule applies.

Source	Web address
IRS: Retirement plans and business mergers	https://www.irs.gov/retirement-plans/plan-participant-employee/retirement-topics-employer-merges-with-another-company
IRS: 401(k) plan termination	https://www.irs.gov/retirement-plans/plan-sponsor/401k-plan-termination
DOL: COBRA continuation coverage	https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra
DOL: Form 5500 reporting	https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500
IRS: Applicable large employer determinations	https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer
IRS: Publication 969, HSAs and other tax-favored health plans	https://www.irs.gov/publications/p969
HHS: Employers and health information in the workplace	https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

References reviewed November 5, 2026. Request periods and 30, 60 and 90 day reviews are planning suggestions, not statutory deadlines. Retirement, pension, multiemployer, executive and retiree arrangements may need specialized review.

ABOUT THIS GUIDE

This guide is a general educational resource and acquisition planning aid. It is not legal, insurance, tax, investment or regulatory advice, or a certification of compliance. Requirements vary by plan, transaction structure, employer group and jurisdiction. Confirm decisions with qualified benefits, legal, tax and insurance professionals. Protect employee and dependent information and limit access to authorized recipients.