

Flexible Benefits Plan

Employer Application

Date: _____

Drafting Preference:

- Premium Conversion Only
Flexible Spending Accounts Only
Premium Conversion with Flexible Spending Accounts
Premium Conversion with Health Savings Account
Premium Conversion with Flexible Spending Accounts and Health Savings Account

General Information:

Employer Name: _____ Telephone: _____
Legal Name: _____ Fax: _____
Street Address 1: _____ Tax ID #: _____
Street Address 2: _____ Tax Year End: _____
City, State, Zip: _____
Contact Name: _____ Title: _____
E-Mail: _____

Insurance Agent: _____

- Type of Entity: C-Corporation, S-Corporation, Professional Service Corporation, Sole Proprietorship, Partnership, Limited Liability Company taxed as a: Partnership, Sole Proprietorship, C-Corporation, S-Corporation

- Member of a: Controlled Group (provide entity names, Tax ID #s, plan types sponsored)
Affiliated Service Group (provide same as above)
Not Applicable

Payroll Schedule: Weekly, Bi-Weekly, Semi-Monthly, Monthly
Payroll Processing Date: _____
Pay Period End Date: _____
Total # of Employees: _____

Plan Information:

Effective Date: New Plan, Restatement, Plan #: _____
(please provide copy of current plan, SPD and 5500, if applicable)

Plan Year: Calendar Year (January 1 - December 31), Short Plan Year, Fiscal Year

Open Enrollment: November, December, Other: _____

Available Benefits:

- Types: Premium Conversion
 Health Insurance Dental Insurance Vision Insurance
 Group Term Life STD LTD
 Other: _____ Other: _____ Other: _____

- Flexible Spending Accounts
 Health Care Maximum Election: \$ _____
 All Out-of-Pocket Medical Expenses
 Vision and Dental Expenses Only
 Vision Expenses Only
 Dental Expenses Only
 Dependent Care (Day Care)
 Adoption Assistance

- Health Savings Account

- Flex Credit Dollars: Applicable Not Applicable

Amount Available: \$ _____

- Core Benefits: Must be elected
 Need not be elected if proof of coverage provided

- Cash-Outs: Not Applicable
 _____% of unused amount, payable in:
 Single Sum
 Installments, based on pay periods per year

- Use Restrictions: None. May be used for all benefits.
 Limited to the following benefits:
 Premium Conversion
 Health Care Flexible Spending Account
 Dependent Care Flexible Spending Account
 Adoption Assistance Flexible Spending Account
 Health Savings Account

- Reimbursements: Applicable Not Applicable

- Frequency: Weekly (Friday)
 Monday, Wednesday, Friday
 Daily [increased monthly administration fee applies]

- Method: Check or Direct Deposit
 Check Only
 Direct Deposit Only

- Debit Card: Make available [increased annual administration fee applies]
 Do not make available

Funding: From Employer Account
Routing Number: _____
Account #: _____
Start with Check #: _____
 From ASAP Flex Plans, Inc. Account

Grace Period: Not Applicable [Premium Conversion and/or Health Savings Account]
 30 days following Plan Year end
 60 days following Plan Year end
 90 days following Plan Year end

2½ month Plan Year Extension: Applicable Not Applicable

Following Termination: Not Applicable [Premium Conversion only]
 Only expenses incurred prior to termination
 Expenses incurred through Plan Year end

Order of Payment: Not Applicable
[Premium Conversion or No Health Reimbursement Arrangement]
 Eligible health care expenses must be paid first from this plan
 Eligible health care expenses must be paid first from HRA

Eligibility to Participate:

Excluded Employees: No exclusions
 Employees working less than _____ hours per week
 Seasonal employees
 Employees less than _____ years of age [\geq age 18]
 Employees on probation for _____ months [\leq 24 months]
 Employees on probation for _____ days or less

Eligibility Criteria: Same as group health insurance plans
 Immediate
 Following coverage under a "High deductible health plan"
 Other: _____

Entry Date: First day of month following satisfaction of eligibility criteria
 Date on which eligibility criteria are satisfied
 First day of following Plan Year
 Other: _____

Coverage Extended to: Participant Only
 Participant's Tax Dependents

COBRA Continuation of Benefits: Not Applicable [$<$ 20 employees in prior year]
 Applicable

Forfeitures: Not Applicable [Premium Conversion and/or Health Savings Account]
 Shall reduce expense of administration during current Plan Year
 Shall reduce expense of administration during following Plan Year
 Shall offset losses experienced by the Employer during Plan Year

- Participating Employees:
- Non-Highly Compensated Employees [\leq \$100,000]
 - Premium Conversion
 - Health Care Flexible Spending Account
 - Dependent Care Flexible Spending Account
 - Adoption Assistance Flexible Spending Account
 - Health Savings Account
 - Highly Compensated Employees [$>$ \$100,000]
 - Premium Conversion
 - Health Care Flexible Spending Account
 - Dependent Care Flexible Spending Account
 - Adoption Assistance Flexible Spending Account
 - Health Savings Account
 - Key Employees
[5% owner; 1% owner $>$ \$150,000; officer $>$ \$140,000]
 - Premium Conversion
 - Health Care Flexible Spending Account
 - Dependent Care Flexible Spending Account
 - Adoption Assistance Flexible Spending Account
 - Health Savings Account
 - C-Corporation Owners
 - Premium Conversion
 - Health Care Flexible Spending Account
 - Dependent Care Flexible Spending Account
 - Adoption Assistance Flexible Spending Account
 - Health Savings Account

Miscellaneous:

- Participant Reports: Not Applicable [Premium Conversion and/or Health Savings Accounts]
 Provide annually - by end of month following Plan Year end
 Provide semi-annually - by end of month following Plan Year end and

Insurance Co-Pays: _____

Prescription Co-Pays: _____

Date: _____

Employer Name

By: _____

Printed: _____

Title: _____