Benefit Advantage
800-686-6829
www.benefitadvantage.com

ERISA- COMPLIANT PLAN DOCUMENT INTAKE FORM

Plan Sponsor Information

1. Company Sponsoring the Plan (Legal Name): _____

2. Company's Principal Office (Address): _____

City:_____ State:_____ Zip:_____

3. Company Federal Employer Identification Number (FEIN): _____

4. Principal Contact for the Company:

_____ (____)_____ _____
Name of Individual Phone E-mail

5. Business Entity Type of the Company (Select one):

□ C Corporation □ S Corporation □ LLC business entity □ LLP business entity

□ Government Entity or Church □ Not-for-Profit Corporation □ Partnership □ Sole Proprietorship

6. Legal Names(s) & FEIN(s) of all Related Employer(s) that will participate in Plan: (Use additional paper if needed)

Co. Name:_____ FEIN:_____

Co. Name:_____ FEIN:_____

7. Total number of employees: _____

Plan Information

8. Effective Date. This Plan will be a (Select):

□ New Plan effective date: _____, First Plan Year period:_____ to _____

and each Plan Year (Select):

□ Calendar Year

□ A twelve month period beginning on_____ and ending on _____ or

□ Amending Plan effective from date:_____

9. Plan Number (Consist of three numbers, starting with 5): 5 _____ _____

10. Legal Agent for the Plan (Specify individual's name, address and phone):

_____ ( )_____
Name Phone

_____
Address City State Zip

11. The laws of the State or Commonwealth of _____ will apply to the administration of the Plan.
(Name of State or Commonwealth)

12. Benefits under the Component Benefits Program include (Select all programs, benefits or plans that apply):

a. □ Medical Benefits
b. □ Dental Benefits
c. □ Vision Benefits
d. □ Health Flexible Spending Account
e. □ Health Reimbursement Arrangement
f. □ Dependent Care Flexible Spending Account
□ Other (Specify): _____
g. □ Premium Conversion Plan
h. □ Short-term Disability Benefits
i. □ Long-term Disability Benefits
j. □ AD&D Benefits
k. □ Group Term Life Insurance Benefits
l. □ Employee Assistance Program Benefits
m. □ Legal Assistance Benefits

13. Are any of the above benefits self-insured (Select): □ No □ Yes

If yes, please check which of the above benefits are self-insured:

a.□ b.□ c.□ d.□ e.□ f.□ g.□ h.□ i.□ j.□ k.□ l.□ m.□ □ Other

14. If any benefit is self-insured, does an outside claims administrator pay claims (Select):

□ N/A. All benefits are insured) □ No. There is no outside administrator

□ Yes. Claims Administrator is: _____

a. If yes, does the Claims Administrator make the final decision on claims, and should it be named as; Named Fiduciary for any claims decisions (Select): □ N/A □ No □ Yes

b. The Named Fiduciary under the Plan shall be (Select):

□ The Company sponsoring the plan □ The Plan Administrator

□ Other (Specify): Name_____ Title _____

15. Is/are the Medical Benefit(s) grandfathered? (Select): □ No □ Yes

If some Medical benefits are grandfathered and others are not, please specify:

_____

16. Special enrollment rights under HIPAA for gaining a new dependent or losing coverage will apply to the following benefits (Specify all that apply):

□ Medical □ Dental □ Vision

□ Health Reimbursement Arrangement □ Employee Assistance Program □ Wellness Program

□ Other (Specify):_____

17. Benefits Coverage during FMLA (Select): □ FMLA does not apply □ FMLA applies

and (Select): □ all benefits under Component Benefit Program □ only "medical benefits" continue

□ medical benefits and following other benefits continue: (Specify):_____

_____

a. If employee contributions are required, the employee makes contributions (Select all that apply):

□ before the beginning of leave □ during leave □ after leave is completed & returns

18. Benefits Coverage during all other Approved Leaves of Absence (Select one):

□ all benefits continue during the approved leave □ only "medical benefits" will continue during an approved leave

□ no benefits will continue during an approved leave and the employee will be treated as terminated

□ Other (Specify):_____

19. Termination of Participation. The following events will terminate participation (Select all that apply):

□ Termination of employment □ Reduction of hours □ Submits false claims

□ Transfer to non-eligible employee group

□ The loss or eligibility in one or all of the benefits under the Component Benefit Program, and/or

□ Other (Specify):_____

20. Rehired Employees. If an employee is rehired, he or she will be reinstated with the same benefit options (Select one):

□ N/A rehired employees are treated as new employees □ 30 days □ 60 days □ 90 days

□ Other (Specify): _____

21. Under COBRA or State Continuation, the following benefits will be offered (Specify all benefits that apply):

□ Medical □ Dental □ Vision □ Health Flexible Spending Account

□ Wellness Program □ Health Reimbursement Arrangement □ Employee Assistance Program

□ (Specify): _____

22. When an employee or their Qualified Beneficiary elects COBRA coverage is there one election for all benefits

(Select): □ Yes □ No there is a separate election for each benefit

23. The Plan Administrator under the Plan shall be (Select one):

□ The Company sponsoring the Plan □ A committee appointed by the Company

□ An Individual (Specify):_____

□ Other (Specify):_____

24. The Named Fiduciary under the Plan shall be (Select one):

□ the Company sponsoring the plan □ the Plan Administrator

□ Other (Specify name and title):_____

25. For any benefits that are self-funded the Named Fiduciary under the Plan shall be (Select one):

□ N/A. No benefits are self-funded □ the Company sponsoring the Plan

□ the Plan Administrator □ Other (Specify) : _____

Self-Insured Information

26. For purposes of determining the amount of, and entitlement to benefits under the Component Benefit Program provided through the Employer's general assets,

(Select): □ the Plan Administrator □ the Claim Administrator

with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

27. To obtain benefits from a self-funded arrangement, you must complete, execute and submit to

(Select): □ the Plan Administrator or □ the Claim Administrator ,a written claim.

28. (Select): □ The Plan Administrator or □ The Claim Administrator
,has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

29. (Select): □ The Plan Administrator or □ The Claim Administrator
will decide your claim in accordance with reasonable claims procedures, as required by ERISA.

30. (Select): □ The Plan Administrator or □ The Claim Administrator
has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

31. If (Select): □ the Plan Administrator or □ the Claim Administrator
denies a claim, in whole or in part, a written notification will be sent setting forth the reason(s) for the denial.

32. If a claim is denied, an appeal to the Named Fiduciary for a review of the denied claim may be made. For the purpose of determining the appeal,

(Select): □ The Plan Administrator □ The Claim Administrator
shall be designated as the Name Fiduciary.