PREMIUM ONLY PLAN REQUEST FORM

Please complete this form and send it along with payment of **$300** payable to:
Benefit Advantage, Attn: Finance, P.O. Box 5490, De Pere, WI 54115-5490

Name of Organization:____

(Enter name **EXACTLY** as it appears on tax returns and is to appear in the documents.)

HR Contact: ______________________________ Title: ______________________

Phone:_______________ Fax:_______________ Email:______________________

Mailing Address:____

Street Address: ____

City: _________________________ State:______________ Zip:_______________

Federal Employer ID No: ________________ Date Incorporated:___/___/___ Total #EE:________

Mail POP Kit to: ____

____

Organization Type: (Federal Classification)

- ☐ Corporation
- ☐ Professional Corporation
- ☐ Partnership
- ☐ Government Agency
- ☐ Other
- ☐ Sub-chapter “S” Corporation
- ☐ Professional Association
- ☐ Sole Proprietorship
- ☐ LLC Limited Liability Company

NOTE:
Only employees can participate in a Cafeteria Plan.
Thus, while partnerships, sole proprietorships and Sub-chapter “S” corporations may sponsor Cafeteria Plans, the following cannot participate: sole proprietors, partners, and greater than 2% shareholders in Sub-chapter “S” corporations.

The Employer/Organization entity is operating pursuant to the laws of the State of: ______

Principal Business Activity Code (six digits): ____ ____ ____ ____ ____ ____

Nature of Business (**BE SPECIFIC**): ____

PLAN ELECTIONS

Plan Number:________ (Starts with 501 if this is your first plan. i.e. 502, etc. based on the filing Form 5500, if applicable).

Plan Begin Date: ______ /______ /______

Plan End Date: ______/ ______/ ______

Insurance Plan Year Runs:______ /______ to ______ /______

Do you have an existing FSA: ______ If yes, with who: ___________________________

NOTE: Premium Only Plans with over 100 participants are required to file an annual 5500.
Benefit Advantage offers this service at a nominal fee.

ELIGIBILITY REQUIREMENTS

Tax penalties may be imposed if the Plan contains eligibility requirements that have the effect of favoring highly compensated employees. Consult your tax advisor before limiting participation in the Plan. **All Premium Only Plans (regardless of size) are required to perform an annual nondiscrimination test.** Benefit Advantage offers this service at a nominal fee.

1. The following class of employees is eligible to participate:
   - ☐ All ☐ Salaried Employees Only ☐ Hourly Employees Only
   - ☐ Other:____

2. The following employees are excluded from participation:
   - ☐ No exclusions.
   - ☐ Employees under the age of:__________.
   - ☐ Not Eligible, if employee worked less than ________ hours per week.
   - ☐ Not Eligible, if employee worked less than ________ hours per month.

3. The service period employees must complete before being eligible to participate is as follows:
   - ☐ Incorporated by reference to the underlying policies of our insurance plan.
   - ☐ As of date of hire.
   - ☐ Number of days after date of hire:________________
   - ☐ Number of months after date of hire:_______________

4. Once the service period is met, the employees can begin participating in the plan:
   - ☐ Date the requirements are met.
   - ☐ First pay date, after requirements are met.
   - ☐ First of month, after requirements are met.
   - ☐ First of quarter after requirements are met.
   - ☐ First of the Plan Year after requirements are met.

BENEFITS

Check the benefits to be offered under this Plan:

- ☐ Core Health Benefits
- ☐ Short Term Disability Benefits
- ☐ Long Term Disability Benefits
- ☐ Non-Core Supplemental Health Benefits (includes vision & dental)
- ☐ Group Term Life Benefits
- ☐ HSA Contributions

Completed by Agent: Agent Name: ______________________________

Agency: ________________________ New Agent? Y or N Agent ID#: __________

Address:____

City, State, Zip:____________________________________

Phone:______________ Fax:________________ Email:________________ Tax ID#:__________

Internal Use Only Section:

BA Consultant:_______________ Customer #: ______________ Fee:_____________ Collected: **Y** or **N**

Note: Please make sure the information provided on this application is correct, as it is pertinent to your plan document. There will be a $50 charge for each amendment requested.