Benefit Advantage

SECTION 132(f) TRANSPORTATION PROGRAM
EMPLOYER APPLICATION

Please complete this form and send it with fee payable to: Benefit Advantage, Attn: Finance, P.O. Box 5490, De Pere, WI 54115-5490

Legal name of Company | Federal Employer ID Number (FEIN)

Physical Address | City | State | Zip

☐ Check if mailing address is the same as physical address.

Mailing Address | City | State | Zip

Main Contact | ( ) Telephone/ Extension | ( ) Fax | E-mail

Account's Payable Contact | ( ) Telephone /Extension | ( ) Fax | E-mail

ORGANIZATION TYPE: (Federal Classification)

☐ Corporation ☐ Sub-chapter "S" Corporation ☐ Professional Corporation ☐ Professional Association
☐ Partnership ☐ Sole Proprietorship ☐ Government Agency ☐ LLC Limited Liability Company
☐ Other (specify):_____

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

Date Incorporated: _____/_____/_____

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

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

Note: Per IRS Regulations, Section 132 excludes sole proprietors, partners, and individuals owning 2% or more shares in an S-Corporation (along with their immediate family members from participating in this plan. They may, however, sponsor the plan for their employees.

Plan Year Information:

Initial Plan year: Effective Date _____/_____/_____ through _____/_____/_____

Subsequent plan years: Effective Date _____/_____/_____ through _____/_____/_____

Payroll Frequency: (check all that apply) ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

Payroll Date - The first payroll date the pre-tax deductions will be withheld on is:_____

Note: Deductions withheld within the plan year should be posted to that plan year.

Number of payrolls first plan year: _____ each following plan year: _____

If there are other divisions participating, will the deductions be sent all together with one form of payment? **Y** or **N**

If no, please list each division and contact name responsible for the deduction payments, and payroll frequency: _____

Plan Number - The number assigned to this plan is _____ (i.e., 501, 502, etc. based on the filing Form 5500)

Eligibility Requirements - Each new employee shall be eligible to participate in the plan after they satisfy the following criteria:

Age Limitations: **Y** or **N** If yes, an employee must be at least _____#years old in order to participate in this plan.

Hours of Service: **Y** or **N** If yes, an employee must work _____#hours for the employer to participate in this plan.

Length of Service Limitations: **Y** or **N** If yes, please specify below:

An employee must work: (fill in one) _____#days, or _____ # months, or _____ #years before participating in this plan

Coverage Effective Date:

☐ Immediate after service limitations are met.

☐ Coverage begins on the first of the (check one) ☐ month ☐ year ☐ quarter after service limitations are met.

Employment Classification Limitations: **Y** or **N** If yes, please check all that apply:

☐ Salaried ☐ Hourly ☐ Union

Is the employer part of a control group of entities or an affiliated service group? **Y** or **N**

If yes, please list: _____

Claim Submission Periods:

The Closing Period is the period of time that begins at the Plan Year end during which the employee can submit claims for payment of Qualified Expenses under that Plan Year. This period begins at the end of the Plan year and terminates (circle one):

30 days 60 days 90 days Other (specify): _____ after the end of the current Transportation plan year.

Note: The closing period for termed employees would be the same as stated above.

Will you be implementing the debit card? Y ☐ N ☐ If yes, a Debit Card Application must be completed and attached to this application

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Transportation Benefits (check all benefits to be included in your Transportation Plan Document):

☐ Qualified Parking

☐ Transit and Van Pooling

Program Funding Arrangements: Payment method **MUST** be checked.

☐ **ACH** – Benefit Advantage initiates the transfer for payroll deductions. Administration fees will be pulled ACH also. The employer sends backup detail for each payroll deduction via fax (920-339-0038) or email (fsadeposits@benadvan.com).

☐ **Manual Check** – The employer sends payment along with backup detail for each payroll deduction to: Benefit Advantage, PO Box 5546, De Pere, WI 54115

Agent/Broker Name: _____

Phone:

BA Consultant: _____ Customer # _____ Enrollment Fee: _____ Collected: Y or N

Per Participant Fee: _____ Renewal Fee: _____

Benefit Advantage, Inc. sends to clients a Welcome Kit which includes verification of pricing and a standard service agreement. Please sign, date, and return. Failure to sign, date and return while accepting services will be viewed as acceptance of our standard business terms and conditions.