

**PREMIUM REDUCTION OPTION  
DATA GATHERING FORM**

Name of Organization: \_\_\_\_\_  
(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Employer ID No: \_\_\_\_\_ Date Incorporated/Organized: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ Zip: \_\_\_\_\_

- Organization Type:  Corporation.  Sub-chapter "S" Corporation  
 Professional Corporation  Professional Association  
 Partnership  Sole Proprietorship  
 Government Agency  LLC Limited Liability Company  
 Other \_\_\_\_\_

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. List affiliates and subsidiaries plus organization type.

The Employer/Organization entity is operating pursuant to the laws of the State of \_\_\_\_\_.

**PLAN ELECTIONS**

Plan No.:  501  \_\_\_\_\_ Plan Name: Section 125 Cafeteria Plan

Plan Begin Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Plan End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Plan Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ First Year Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ELIGIBILITY REQUIREMENTS**

1. The following class of employees is eligible to participate:

- All  Salaried Employees Only  Hourly Employees Only  
 Other \_\_\_\_\_

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.

2. The following employees are excluded from participation:

- No exclusions.  
 Part-time employees normally expected to work less than \_\_\_\_\_ hours a week.  
 Employees under the age of \_\_\_\_\_.  
 Union employees (unless the bargaining agreement provides for coverage).  
 Non-resident aliens.  
 Other: \_\_\_\_\_

Section 125 does not specifically provide for election exclusions. Consult your tax advisor before excluding any classification(s) of employees.

3. The service period employees must complete before being eligible to participate is as follows:

- Incorporated by reference to the underlying policies.
- For the initial plan year, any one employed on the Plan Effective Date and for subsequent Plan Years
  - As of date of hire.
  - Number of days after date of hire: \_\_\_\_\_
  - Number of months after date of hire: \_\_\_\_\_
- For all plan years
  - As of date of hire.
  - Number of days after date of hire: \_\_\_\_\_
  - Number of months after date of hire: \_\_\_\_\_

Employees must be in service or on the job as one of the eligibility requirements.

4. Once the employees are eligible, they can begin participating in the plan:

- Date employee becomes eligible.
- First day of pay period following the date employee becomes eligible.
- First day of month following the date employee becomes eligible.
- First day of quarter following the date employee becomes eligible.
- First day of Plan Year following the date employee becomes eligible.

### BENEFITS

Check the benefits to be offered under this Plan:

- Core Health Benefits
- Non-Core Supplemental Health Benefits
- Group Term Life Benefits
- Short Term Disability Benefits
- Long Term Disability Benefits
- Cash Benefits (opt out of health insurance) Employer Credits for opt out: \$\_\_\_\_\_
- HSA Contributions

### CONTRIBUTIONS

Overall Maximum for all Benefits: \$\_\_\_\_\_

Cannot be beyond reach of all employees. Rule of thumb: Do not exceed estimated annual salary of lowest paid eligible employee on the payroll which will be prorated for any Plan Year less than 12 months.

### BENEFIT COORDINATOR

The Benefit Coordinator is the individual at the Employer with whom Employees should communicate.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

e-mail \_\_\_\_\_ Website: \_\_\_\_\_

**LEGAL ACCEPTANCE**

The Legal Acceptance is the individual at the Employer who is responsible for signing the plan document. This typically would be the owner or president and the secretary.

Name: \_\_\_\_\_

Title: \_\_\_\_\_ (usually President)

Name: \_\_\_\_\_

Title: \_\_\_\_\_ (usually Secretary)

**ADMINISTRATIVE FEES**

\$\_\_\_\_\_ installation fee

\$\_\_\_\_\_ discrimination testing fee

These documents are being printed at the direction of the person named below. It is understood that Human Resource Administrators, Inc. is not engaged in the practice of law. Any unanswered questions may result in errors in the Plan produced by using the information form this worksheet. I understand that in the preparing the document requested, Human Resource Administrators, Inc. is utilizing information shown on this Data Gathering Form to produce documents using a format which has been designed by Human Resource Administrators, Inc. and Human Resource Administrators, Inc. has made NO REPRESENTATION OR WARRANTY OF ANY KIND, expressed or implied, including no warranties of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, nor is any opinion, expressed or implied, rendered by its attorney's as to the legal effect, sufficiency or tax qualification of any document utilizing Human Resource Administrators, Inc. format.

\_\_\_\_\_  
Signature (Required)

\_\_\_\_\_  
Date