

1. Name of Employer: (exactly as it is to appear with punctuation)

a. _____

b. _____

2. Employer's Address:

a. _____
(Street--Physical not P.O. Box)

b. _____ c. _____ d. _____
(City) (State) (Zip)

e. Telephone () _____

3. Employer's Tax ID No.: a. _____

4. Plan Number (circle one): a. 501 502 503 504 505

5. Plan Administrator shall be:

a. Employer, using Employer's address
OR

b. Other _____
(Name)

AND, if Other selected

c. Use Employer's address

d. Use address below...

1. _____
(Street--Physical not P.O. Box)

2. _____ 3. _____ 4. _____
(City) (State) (Zip)

5. Telephone () _____

6. Plan's Agent for service of legal process is:

a. Employer, using Employer's address

b. Plan Administrator

c. Other _____
(Name)

AND

d. Use Employer's address (automatically selected if 7a. chosen)

e. Use address below...

1. _____
(Street--Physical not P.O. Box)

2. _____ (City) (State) (Zip)

7. Employer's Principal Office: a. _____
(State)

8. Plan Information:

a. New Plan

b. Amendment and Restatement

9. Plan Name/Title of Document: (exactly as it is to appear with punctuation)

a. _____

b. _____

c. _____

10. Plan Year:

a. Begins _____
(month) (day)

b. Ends _____
(month) (day)

Is first year a short Plan Year?

c. Yes, beginning _____
(month) (day)

d. N/A

11. Effective Date(s):

a. Initial Effective Date _____
(month) (day) (year)

b. This Restatement _____
(month) (day) (year)

12. Employer Entity:

a. S Corporation (2% shareholders not eligible)

b. Corporation

c. Partnership (self-employed (partners) not eligible)

d. Sole Proprietorship (self-employed not eligible)

e. Governmental Entity or Church

f. Non-Profit Organization

g. Limited Liability Company (members not eligible)

Note: 12a., c., d., & g., add a provision that excludes the group in parentheses from participating in the plan.

13. Eligible Class of Employees:

a. All Employees who satisfy eligibility requirements

b. Salaried Employees only

c. Hourly Employees only

d. All Employees except:

1. Commissioned Employees

2. Union Employees

3. Leased Employees

4. Part-time Employees, expected to work less than _____ hours per week

5. Nonresident Aliens

6. Employees not eligible under Employer's group medical plan

7. Other _____

14. Conditions for Eligibility:

a. Same as Employer's group medical plan
OR

b. For **first** Plan Year **only**, anyone employed on the effective date of the Plan is eligible, **thereafter:**
(choose one from d-g below)

OR

c. For **all** years, eligibility is as follows:
(choose one from d-g below)

d. Date of hire (no service required)

e. _____ years after date of hire

f. _____ days after date of hire

g. _____ months after date of hire

AND

For Health Care Reimbursement Fund only, eligibility is as follows:

h. No Health Care Reimbursement, or eligibility is the same as above for all benefits

i. _____ days after date of hire

j. _____ months after date of hire

k. _____ years after date of hire

Note: If option i., j. or k. selected, 20I. must be selected.

15. Entry Date:

- a. First day of the pay period next following date requirements were met
- b. Date conditions for eligibility are met
- c. Dual entry (1st day of Plan Year & 6 months later)
- d. First day of Plan Year following date requirements were met
- e. First day of month following date requirements were met
- f. Same as Employer's group medical plan

16. Family and Medical Leave Act: Is the Employer subject to these provisions?

- a. No
- b. Yes

17. Contributions. Plan will provide for...

- a. Salary reduction contributions **ONLY**
(no Employer contributions) (skip to 20)
- b. Employer contributions **ONLY**
(no salary reductions) (answer 19, then skip to 21)
- c. Both salary reductions **AND** Employer contributions

18. Employer Contributions. For each Plan Year, Employer will contribute...

- N/A
- a. _____% of compensation per Participant
- b. \$ _____ per Participant
- c. Discretionary
- d. Other _____

AND, the contributions shall be made...

- e. At beginning of Plan Year
- f. Pro rata each pay period

AND, the contributions are convertible to cash

- g. Yes
- h. No

Note: Option **h.** may not be selected with **17b.****19. Salary Reduction Election.** For each Plan Year Employees may elect to reduce compensation to purchase all plan benefits by...

- a. Up to _____% each Plan Year
- b. From _____% to c. _____% each Plan Year
- d. Up to \$ _____ each Plan Year

OR

- e. Amounts sufficient to support benefits elected

Note: The maximum in this question applies to all benefits under the Plan combined.**Benefit Options.** Plan to provide...

- k. Flexible Spending Accounts. (automatically selected)

AND, Maximum salary reduction amount shall be

- f. N/A (if 20i is chosen, must select 24d)
- g. \$ _____ per pay period
- h. \$ _____ per Plan Year
- i. _____% of compensation

Note: Regulations require either a maximum or formula for determining such be stated in the Plan Document. The Health Care Reimbursement Plan maximum must be selected at **23d**. The Dependent Care Assistance Program maximum is the statutory limit standard in the plan document.**20. Flexible Spending Accounts** will be established for...

(select all that apply)

- l. Health Care Reimbursement Plan
- m. Dependent Care Assistance Program
- AND** include account for insurance premium payments
- n. Yes, include Premium Payment Account
-- must check applicable coverage below and at question 21
- o. No (skip to 23)

Premium Payments may be elected for...

- a. Health insurance (individual **AND** dependent coverage)

OR

- b. Dependent health insurance **ONLY**

OR

- c. No group health insurance

AND

- d. Group-term life insurance
- e. Disability insurance
- f. Dental insurance
- g. Cancer insurance
- h. Vision insurance
- i. Accidental Death and Dismemberment insurance
- j. Prescription Drug Coverage
- k. Other Insurance Coverage

Note: **k.** adds language that allows for other types of health coverage not listed above.**21. Are the health premium payments elected above self-insured by the Employer?**

- a. Yes
- b. No

22. For Health and Disability Insurance, may Participants seek reimbursement for individual policies through the Premium Conversion Plan?

- a. N/A
- b. Yes, at the Administrator's discretion
- c. No

23. Benefit Limitations: (select as applicable)

- a. N/A--No limitations (skip to 24)
- b. Group-term life insurance premiums needed to purchase:
1. _____ times compensation
 2. \$50,000
 3. lesser of _____ times compensation or \$50,000
 4. N/A

Note: Insurance over \$50,000 could result in taxation to Employees.

- c. Disability shall be limited to _____% of compensation
- d. \$ _____ shall be maximum participant allocation to Health Care Reimbursement Fund

Note: If not selected, Policy will control. Option **d.** may only be selected with **20i**.

- e. Maximum salary reduction to 401(k) Plan may not exceed _____% of compensation

Note: If no selection made, provision of 401(k) Plan will control.**24. Benefit Election Period shall be...**

- a. The _____ day period prior to each Plan Year
- b. From the _____ day to 1. _____ day period prior to each Plan Year
- c. Established by Administrator in nondiscriminatory manner

25. Is automatic enrollment for insured benefits provided under this Plan?

- a. Yes
- b. No

Note: Option a. may only be selected with 20n.

26. Participants who fail to sign a new election form shall...

- a. Continue same elections as prior year
- b. Be considered to have elected not to participate for upcoming Plan Year
- c. Continue same elections as prior year only for insured benefits

27. Will Affiliated Employers execute this Plan?

- a. N/A or No
- b. Yes, include signature lines for:

1. _____
(Name)

2. _____
(Street)

3. _____
(City) (State) (Zip)

4. _____
(ID No.)

28. Will there be a second Affiliated Employer?

- a. No
- b. Yes

1. _____
(Name)

2. _____
(Street)

3. _____
(City) (State) (Zip)

4. _____
(ID No.)

29. Will there be a third Affiliated Employer?

- a. No
- b. Yes

1. _____
(Name)

2. _____
(Street)

3. _____
(City) (State) (Zip)

4. _____
(ID No.)

30. Witnesses to Employer's signature:

- a. Yes
- b. No

Note: State law may require witnesses to the Employer's signature.

31. Supplemental Participation Agreement Requested:

(Select "Yes" only if other Employers are affiliated with this Plan)

- a. N/A - No Supplemental Participation Agreement
- b. Yes - Supplemental Participation Agreement to be included

32. For a Health Care Reimbursement Plan, terminated Employees shall...

- a. Continue contributions and reimbursements for the remainder of the Plan Year
- b. Cease contributions and reimbursements upon termination
- c. Continue or cease at Participant's election
- d. N/A--Health Care Reimbursement Plan is not offered

33. For a Health Care Reimbursement Plan, new election due to change in family status permitted?

- a. No
- b. Yes
- c. Yes, only if salary redirections to the medical account are increased
- d. N/A--Health Care Reimbursement Plan is not offered

Note: Options a. & c. may reduce Employer's risk of loss.

34. Is a 401(k) Plan a benefit under this Cafeteria Plan?

- a. Yes, name of Plan:

b. No or N/A

35. May Participants convert vacation days into Cafeteria Plan benefit dollars?

- a. Yes
- b. No

36. Claims for Reimbursement must be filed within (select all that apply)

- a. _____ days following each Plan Year
(applies only to 20l or m)
- b. _____ days following termination of employment
(applies only to 20l or m)

37. Claims should be submitted to:

- a. Employer, using Employer's address
- b. _____ at address below:

1. _____

2. _____
(City) (State) (Zip)

38. Are employer provided debit or credit cards used for medical expenses?

- a. Yes
- b. No