



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

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

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 from 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