Secure Benefits Systems Section 125 Cafeteria Request Form

(fax: 1-712-336-0208 // email: vrenae@sbsc.info)

Submitting Agent Information (If none leave blank)

First Name_____ Last Name_____

Company_____

Address_____

City_____ State_____ Zip Code _____

Email_____

Ship Document to: ☐Agent ☐Employer

Employer Information for Plan Documents – Exactly as it should appear in the plan document. Print clearly.

First Name_____ Last Name_____ (owner/controller, document signer)

Company Name_____

Address_____

City_____ State_____ Zip Code_____

Phone _____ Fax _____

Email_____

Form of Business: ☐S Corporation ☐C Corporation ☐LLC ☐Partnership

☐Sole Proprietorship ☐Government ☐Non-Profit 501(c)(3)

Employer Federal ID#:_____ State of Inc.: _____ Number of Employees: _____

Legal Name(s) of Affiliated Company(ies) that will be covered by the Plan (if none leave blank):

_____

Effective Date will be:

☐a) A new plan effective date as of (date) _____

☐b) Amend and restate an existing Section 125 POP as of (new date for this updated plan): _____

Plan Year – The first plan year will be

☐ a) a 12 consecutive month period beginning (date)_____ and ending (date)_____

☐ b) a short plan year beginning (date)_____ and ending (date)_____

Eligible Class of Employees:

☐All employees or:

☐All employees EXCEPT: (check and or circle all that apply)

☐Employees not eligible for group medical plan

☐Employees working less than _____ hours/months per week/year. (Cannot exceed 30 hours/week)

☐Other:_____

Conditions for Eligibility: (Cannot exceed 90 days total):

☐Same as Employer's Group Medical Plan:_____ ☐Date of Hire(No service required) ☐_____ days after date of hire

Plan Entry Date:

☐First day of pay period next following date requirements were met ☐First day of month following date requirements were met

☐Date conditions of eligibility were met ☐Same as Employer's Group medical plan

Benefit Options (check all that apply):

(Note: for all Section 125 Cafeteria Plan document requests, Premium Pass Only language is automatically included)

1. _____ Health FSA (Option automatically has a 90 day run-out period)
   a) Unreimbursed medical limit $_____ (cannot exceed IRS limit)
   b) Carryover option ___Yes ___ No (By selecting this option we will implement the IRS allowed limit at the time of request)
   c) 2 ½ month Grace Period ___Yes ___No (Cannot offer both Grace and Carryover)
   d) Neither Grace or Carryover _____

2. _____Dependent Care FSA (Option automatically has 90 day run-out period)
   (IRS annual limit is $5,000 for married filing jointly and $2,500 for single or married filing separately.)
   a) 2 ½ month Grace Period allowed? ___ Yes ___ No

3. _____ Individually Owned Premium Plans (Medical/Health plans not eligible)
   (Includes Cancer, Dental, Vision and Prescription Drug Plans)

4. Do you offer an HSA plan? _____ Yes _____ No

Reimbursement Options: (check all that apply)

___ Checks
___ Direct Deposit
___ Debit Cards for Health FSA (Additional fees apply)

Plan Contributions: (check all that apply)

1. ___Employee salary reduction contributions
   ___Employer Contributions (limitations apply)

2. Number of pay periods per year ____ (that deductions will be taken)

3. How often do you want reimbursements processed?(weekly, semi monthly, etc)? _____

Please provide pay period schedule

Initial Plan Year Pay Period Dates:

January _____
February _____
March _____
April _____
May _____
June _____
July_____
August _____
September _____
October _____
November _____
December _____

By signing I authorize Secure Benefits Systems to set up Section 125 Documents and agree to set up/pay fee at the time of processing. Payment can be sent to address below.

Employer Signature:_____ Date:_____