

New Plan

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

Amended & Restated

Effective Date of Amended/Restated Plan: \_\_\_\_\_

Plan Effective Date: \_\_\_\_\_ Short Plan Year: \_\_\_Y \_\_\_N

**EMPLOYER INFORMATION DATA FOR SECTION 125 PLAN SETUP**

Type of Plan filing for: \_\_\_\_\_ Flexible Spending Account \_\_\_\_\_ Flex Dollars \_\_\_\_\_ Premium Pass Only

Do you currently have an HSA in place? \_\_\_\_\_ YES \_\_\_\_\_ NO

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

Type of Company: \_\_\_ Sole Proprietor \_\_\_ Partnership \_\_\_ C Corp \_\_\_ S Corp \_\_\_ LLC \_\_\_ Gov't Entity or Church

Company Federal ID#: \_\_\_\_\_ Approximate # of Employees: \_\_\_\_\_

Company Contact Person: \_\_\_\_\_ Contact Email Address: \_\_\_\_\_

Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Contact Fax Number: \_\_\_\_\_

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**Eligible Class of Employees:**

All employees

All employees EXCEPT:

Employees not eligible for group medical plan

Employees working less than \_\_\_ hours/months

Per week/year. (cannot exceed 30 hours/wk)

Other: \_\_\_\_\_

Unreimbursed Medical Limit: \$ \_\_\_\_\_

\$500 Carry-over rule option: YES \_\_\_\_\_ NO \_\_\_\_\_

**Administrative Fee:**

\$ \_\_\_\_\_ per month = \$ \_\_\_\_\_ per pay period

Fee Paid by: \_\_\_\_\_ Employer \_\_\_\_\_ Employee

Monthly maintenance fee/month = \$ \_\_\_\_\_

**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

\_\_\_\_\_ months after date of hire

# of Employee Reimbursements per year:

\_\_\_\_\_ 24 \_\_\_\_\_ 26 \_\_\_\_\_ 52

Number of Pay Periods per year: \_\_\_\_\_

**Separate eligibility requirements for Unreimbursed Medical Only? \_\_\_\_\_ YES \_\_\_\_\_ NO**

If yes: please explain: \_\_\_\_\_

**Initial Plan Year Pay Period Dates:**

January \_\_\_\_\_ July \_\_\_\_\_

February \_\_\_\_\_ August \_\_\_\_\_

March \_\_\_\_\_ September \_\_\_\_\_

April \_\_\_\_\_ October \_\_\_\_\_

May \_\_\_\_\_ November \_\_\_\_\_

June \_\_\_\_\_ December \_\_\_\_\_

**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

Submitting Agent: \_\_\_\_\_

Submitting Agent Phone: \_\_\_\_\_

REIMBURSEMENT OPTIONS : \_\_\_\_\_ Checks \_\_\_\_\_ Direct Deposits \_\_\_\_\_ Debit Cards (additional fees apply)

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Return Completed form to:

**SECURE BENEFITS SYSTEMS**

P.O. Box 469, Okobojo, IA 51355 or FAX: 712.336.0209

Questions? 800.562.8454