☐ New Plan

☐ Amended & Restated

Plan Begin Date:____________Plan End Date:_______________

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**:__________________________

CompanyAddress:_________________________________**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:_________________________________

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

Separate eligibility requirements for Unreimbursed Medical Only? _____YES _____NO

If yes: please explain:___________________________

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

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 = $________

# of Employee Reimbursements per year:

_____24 _____26 _____52

Number of Pay Periods per year: _________

Initial Plan Year Pay Period Dates:

January __________ July ________________

February __________ August______________

March ____________ September___________

April _____________ October ____________

May ______________ November __________

June ______________ December __________

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, Okoboji, IA 51355 or FAX: 712.336.0209

Questions? 800.562.8454