

Document Preparation Sheet

Company Information:

- Employer Name _____
- Mailing Address _____
_____ Zip _____
- Contact Name: _____ E-Mail _____
- Company Website (if any) _____
- Telephone Number _____ Fax Number _____
- Fiscal Year of Business (*business bookkeeping year*) _____
- Employer ID # (EIN) _____
- Principle Business Activity: _____
- Business Entity (check one) Corp Sub S Corp LLC Partnership
 Non-Profit Sole Proprietor _____ Other (specify)
Please note that owners of S Corps, Sole Proprietorships and Partnerships cannot participate. Premium Only Plans can only be used for group medical insurance premiums.
- First payroll after plan start ___/___/___; Number payrolls remaining in yr _____.

Type of Plan: New Takeover If takeover orig eff. date _____

- Premium Only Plan (POP)** **Premium Only Plan (POP with HSA)**
- Premium Only Plan (POP with HSA and Dependent Day Care)**
- Full Cafeteria Plan** Annual Medical Limit Per Employee \$ _____
- Health Reimbursement Account (HRA) (See additional provisions below.)**

Note: Plan allows for pretax contributions for medical, dental, life and disability insurance.

Employee Eligibility for Plan:

- Employee Hour and Age Requirements _____ hours per week and _____ years of age
- Length of Employee Service Before Eligible _____ none _____ 1 mo. _____ 3 mo. _____ 6 mo. _____ 12mo. _____ 24 mo.
- Date of Employee Eligibility (check one) _____ First of the month following fulfillment of hour, age, and service requirements; or _____ Other (specify) _____
- COBRA Eligible _____ yes _____ no
- Number of eligible employees _____

If Premium only - Automatic Enrollment (negative election) : Yes _____ No _____

Life Insurance: Yes _____ No _____ Disability Insurance: Yes _____ No _____

Note: The eligibility provisions for Premium Only Plans generally mirror eligibility requirements for insurance.

Employer Contributions :

- Is the employer paying for insurance premium? Yes _____ No _____ If yes, does the employer offer cash if the participant doesn't elect insurance? Yes _____ No _____.
- Is the employer contributing to the Flexible Spending Account? If yes, fixed dollar amount _____ or percent of compensation _____. (flexible spending accounts only).

Plan Information:

- Effective Date of Plan (this year's beginning date) _____
- Plan Name _____
- Plan Year Begins* _____ Plan Year Ends _____
 *(HRA - Calendar year only)
- Grace Period : 2 and 1/2 Months ____ or none _____
- Run Out Period: How many days after the end of a plan year does a participant have to submit a claim for reimbursement _____
 - **NOTE: Grace Period/Run Out Period – Full Cafeteria Plan only.**
- Plan Trustee(s) ** _____
 ** The Trustees will also be the Administrative Committee Members unless the employer indicates otherwise.
- Do you have other plans in place? yes no Plan Type _____

Health Reimbursement Account (HRA)

- Annual Reimbursement Limit Per:
 Employee \$ _____, Employee/Spouse \$ _____, Employee/Family \$ _____.
- Maximum Percentage of Expenses to be Reimbursed: (check one)
 - 80% 100% _____ Other (specify what % level)
- Carryover: No Yes _____ Amount (credit limit)
- Dental expenses covered No Yes
- Vision expenses covered No Yes
- Prescription Drugs No Yes
- Deductible Expenses Only No Yes
- Must be on Employer Group Health Plan No Yes
- Reimburse off of Explanation of Benefit's (EOB's) only No Yes
- Deductible Employee must meet \$ _____ None _____
- Health Insurance Plan Renewal Date _____
- Other Restrictions on Reimbursements? If Yes, specify _____

Document Routing: Documents prepared using the above information should be routed to:

Employer Broker (for distribution to employer)
 Agent/Broker referral? _____ (Agent name) Self-referral? ____
 Agent phone number and email: no. _____ email: _____

Employer Authorization:

Signature here indicates knowledge of the fees for preparation of the Cafeteria Plan Documents and authorizes this payment upon delivery of the documents. Signature also indicates knowledge that Plan Documents and enrollment forms need to be completed and signed prior to the beginning of a plan year. **All document preparation sheets need to be received in the Professional Benefit Services, Inc. office by the 20th of the month preceding the effective start date of a plan.**

Authorized Signature _____ Date _____

Professional Benefit Services
1193 Royvonne SE, Salem, OR 97302
Ph 800-982-2012 * 503-371-7622 * Fax 503-364-6901
Email cafeteria@profben.com * website: www.profben.com