Document Preparation Sheet

Company Information:

Employer Name ______________________________

Mailing Address ______________________________

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Contact Name: ______________ Email: ______________

Company Website (if any) ______________________________

Phone 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

****Please note that owners of LLC, S Corps, Sole Proprietorships and Partnerships cannot participate. Premium Only Plans can only be used for group medical insurance premiums.**

- COBRA Eligible ______yes ______no
- Number of eligible employees ________________
- Do you have other plans in place? □ yes □ no Plan Type ______________
- Life Insurance: _______Yes______ No Disability Insurance: ______Yes______ No

Employee Eligibility for Plan:

***Plan eligibility should match the company's health insurance.**

- Plan Eligibility will match our group health plan. __________ yes __________no

For FSA or DCA plans or plans with different eligibility than the group health plan:

- Employee Hour Requirements __________ hours/week
- Employee Age Requirements: ______18 ______ 19 ______ 20 ______ 21 ______ NONE
- Length of Employee Service Before Eligible ______none ______ 1 mo. ______2 mo.
- Date of Employee Eligibility (check one) _______First of the month following fulfillment of hour, age, and service requirements; or ______________________________ other

Note: All employees are automatically eligible to participate in the Premium Only Plan (POP) if they are eligible for health insurance.

☐ Cafeteria Plan

Type of Plan: □ New □ Takeover If takeover, original effective date ______________

□ Premium Only Plan (POP) □ Premium Only Plan (POP with HSA) □ Full Cafeteria Plan

□ Premium Only Plan (POP with HSA and Dependent Day Care)

- Effective Date of Plan ______________________________
- Plan Name ______________________________
- Plan Year Begins ______________ Plan Year Ends ______________

Employer Contributions:

- Does the employer offer cash if the participant doesn't elect insurance? ______Yes ______No
- Is the employer contributing to the Flexible Spending Account? ______Yes ______No

If yes, fixed dollar amount ______________ or % of compensation ______________

FSA ONLY:

- Annual Medical Limit Per Employee $ ____________________
- Rollover__________ Yes Amount of Rollover (Maximum of $500) ____________

  *Choose rollover OR grace period – not both.
- Grace Period (Max of 2.5 months) ____________________
- Run Out Period: How many days after the end of a plan year does a participant have to submit a claim for reimbursement: ____________________
- Debit card: _________ Yes _________ No

☐ **Health Reimbursement Account (HRA)**

- Effective Date of Plan ____________________
- Plan Name ____________________
- Plan Year Begins __________ Plan Year Ends __________

(HRA - Calendar year only)

- Annual Reimbursement Limit Per:

  Employee $_______________ EE/Spouse $_______________ EE/Family $________________
- Maximum Percentage of Expenses to be Reimbursed: (check one)

  ▫ 80% ▫ 100% _________ Other (specify what % level)
- Carryover:________ Yes _________ No Amount ____________________
- Dental expenses covered _________ Yes __________ No
- Vision expenses covered _________ Yes __________ No
- Prescription Drugs _________ Yes __________ No
- Deductible Expenses Only _________ Yes __________ No
- Must be on Employer Group Health Plan __________ Yes ____________ No
- Reimburse off of Explanation of Benefit's (EOB's) only: ____________________
- Deductible Employee must meet $ ____________________
- Health Insurance Plan Renewal Date: ____________________
- Other Restrictions on Reimbursements? If Yes, specify ____________________

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Document Routing:

Documents prepared using the above information should be routed to:

▫ Employer ▫ Broker (for distribution to employer)

Agent/Broker name: ____________________

Agent/Broker email: __________ Phone Number: __________

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 prep sheets need to be received in the Professional Benefit Services, Inc. office by the 20th of the month preceding the effective start date of the plan.**

Authorized Signature: ____________________ Date: __________

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