Professional Benefit Services Master Application

Employer Demographic Information							
Employer Name:							
Mailing Address:		City:					
Mailing Address Line 2:		State:		ZIP Code:			
Company Website (if any):		Fiscal Year End(mm/dd):	/				
Employer EIN:		Principal Business Activity:					
Total # of EE's:		Total # of Benefit Eligible EE's:		# of EE's on GHP:			
Business Entity:	☐ C-Corp ☐ *Sub S-Corp ☐ *LLC ☐ Other (specify): _____ ☐ *Partnership ☐ Non-Profit ☐ *Sole Prop						
**Please note that owners of LLC, S-Corps, Sole Proprietorships and Partnerships cannot participate. Premium Only Plans can only be use for group medical premiums.*							
First Payroll After Plan Start:		Number of Payrolls per Year:					
Authorized Plan Contacts							
Primary Plan Contact Name:							
Phone Number:		Fax:		Email:			
Secondary Plan Contact Name:							
Phone Number:		Fax:		Email:			
Advisor/Broker Information							
Advisor Name:							
Phone Number:		Fax:		Email:			
Services							
Type of Plans:	☐ Premium Only Plan (POP) ☐ Premium Only Plan (POP) with HSA ☐ Premium Only Plan with HSA and Dependent Day Care ☐ Full Cafeteria Plan (FSA) ☐ Dependent Care FSA (DCA)			☐ Health Reimbursement Account (HRA) ☐ Limited Purpose Cafeteria Plan (LPFSA) ☐ Transportation Account ☐ Parking Account ☐ COBRA ☐ Retiree			

Fees

Selected Services:	One Time Set-Up Fees	Admin Fee	Min. Monthly Fee	Annual Renewal Fee	Notes

Authorized Signature: _____ Date:_____

Authorized Name (Print):_____