Employer Application
FOR
THE CAFETERIA PLAN

Employer Information

1. Legal Name of Employer Sponsoring the Plan:

____

2. Address of Employer's Principal Office:

____
____
____

3. Federal Employer Identification Number of the Employer: ____________________
.
4. Business Entity Type of Employer (select one that applies):

   a. ☐ C Corporation, b. ☐ S Corporation, c. ☐ LLC business entity,

   d. ☐ LLP business entity, e. ☐ Government Entity or Church,

   f. ☐ Not-for-Profit Entity, g. ☐ Partnership, or h. ☐ Sole Proprietorship.

5. Legal Names(s) and Federal Employer Number(s) of Affiliated Employer(s) who will participate in the Plan:

____
____
____
____

6. Number of employees __________.

Plan Information

1. Effective Date – This Plan will be (Select a or b):

   a. ☐ A new Plan effective from (Insert date) ________________________ ,
   First Plan Year shall be a period from _____________ to ____________or

   b. ☐ Amended effective from (Insert date) ____________________, while the original effective date is ___________________ .

2. Plan Number: 5_ _

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3. Legal agent for the Plan (Specify contact individual's name and address, phone, fax and email):

____

____

____

4. Plan Year (Select a or b):

   a. ☐ Calendar Year, or

   b. ☐ A twelve month period beginning on_________ and ending on _________.

5. The laws of the State or Commonwealth of __________________________ will apply to the administration of the Plan.

6. Eligible Employees (Select a, b, c, d or e):

   a. ☐ All employment classes (Select i, ii or iii):

      i ☐ Working more than 20 hours per week,

      ii ☐ Working more than 30 hours per week, or

      iii ☐ Other ____ .

   b. ☐ Salaried employees (Select i, ii or iii):

      i ☐ Working more than 20 hours per week,

      ii ☐ Working more than 30 hours per week, or

      iii ☐ Other ____ .

   c. ☐ Hourly employees (Select i, ii or iii):

      i ☐ Working more than 20 hours per week,

      ii ☐ Working more than 30 hours per week, or

      iii ☐ Other ____

   d. ☐ Collective Bargaining Unit (Specify): _____________________________
   ____, or

   e. ☐ Other (Specify): ____
   ____
   ____

7. Those employees eligible to participate in the Plan can only participate in the Health Care FSA, if he or she participates in a health plan sponsored by the Employer (Select a or b):

   a. ☐ Yes

   b. ☐ No an eligible employee may participate in the Health Care FSA if even if he or she does participate in the employer's health plan

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8. Waiting Period (Select a, b, c or d):

   a. ☐ 30 days, b. ☐ 60 days, c. ☐ 90 days, or d. ☐ Other (Specify): ____.

9. Participation date after completing waiting period (Select a, b or c):

   a. ☐ First day of the month following,

   b. ☐ The date that eligibility requirements are met,

   c. ☐ Hire date or

   d. ☐ Other (Specify): ____

10. Termination of Participation: The following events will terminate participation (Select all events that apply):

    a. ☐ Reduction of hours, b. ☐ Submits false claims, c.☐ Transfer to

    noneligible employee group, or d. ☐ Other _______________________________ ____ .

11. Once a participant terminates participation, coverage will end for all benefits except for the Dependent Care Flexible Spending Accounts (Select a or b):

    a. ☐ End of the month in which the termination events occurs, or

    b. ☐ the date on which the termination occurs.

12. For Dependent Care Flexible Spending Accounts, coverage will end (Select a, b, c or d):

    a. ☐ N/A. the plan does not contain the benefit, b ☐ Same as Section 11 above,

    c ☐ End of the ____ month following the month in which the termination occurs,

    d. ☐ End of the Plan Year in which the termination occurs.

13. Eligible Expenses or Funding: The benefit programs that are provided under the Plan are as follows (Select all programs that apply):

    a. ☐ Medical Benefit, b. ☐ Dental Benefit, c. ☐ Vision Benefit, d. ☐ Group Term Insurance Benefit, e ☐ Accidental Death and Dismemberment Insurance Benefit, f. ☐ Short-term Disability Benefit, g. ☐ Long-term Disability Benefit, h. ☐ Health Care Flexible Spending Account, ("Health Care FSA Benefit"), i. ☐ Dependent Care Flexible Spending Account ("Dependent Care FSA Benefit"),

    j. ☐ (Specify): ____.

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14. After an Eligible Employee is eligible, he or she has an election period of (Select a, b, c, d or e): a. □ two weeks, b. □ 3 weeks, c. □ 4 weeks, d. □ 30 days, or

    e. ☐ Other (Specify): ___________________________________ to participate.

15. The maximum dollar amount that a participant may contribute to his or her Health Care FSA Benefit for a Plan Year is $ __________________ and the minimum dollar amount is $ ________.

16. Participants shall make Salary Reduction Contributions for this or her Health Care FSA Benefit (Select a, b, c or d):

    a. ☐ Each payroll period, b. ☐ Every other payroll period, c. ☐ Once a month,

    or d. ☐ Other:____

17. The minimum expense that the Health Care Flexible Spending Account will reimburse is (Select a, b, c or d): a. □ $50, b. □ $40, c. □ $30, or d. □ Other (Specify): ____ .

18. Defining Medical Expenses to be reimbursed under the Health care FSA (Select a, b, c, d, e, f, and g):

    a. ☐ Any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 and 105, and the rulings and Treasury regulations; ☐ All medical expenses indicated in subsection a. above except for ___________________________________;

    b. ☐ Medical expenses, but not dental or vision expenses;

    c. ☐ Dental expenses and vision expenses, but not medical expenses;

    d. ☐ Those expenses that would be reimbursed by the Employer's Medical Plan, but for (Select all that apply): i ☐ the deductible, ii ☐ co-payment, iii ☐ co-insurance amounts and/or iv ☐ Other (Specify): ___________________________ ;

    e. ☐ Expenses listed in (Select i, ii, iii iv or v): i ☐ a above, ii ☐ b above, list exceptions ______________________________ , iii ☐ c above. iv ☐ d above or v ☐ e above (Select all that apply) A. ☐ the deductible, B. ☐ co-payment, C ☐ co-insurance amounts or those medical, dental and/or vision plans selected by the employer; and/or D. ☐ Other ____________ and premiums for those medical, dental and/or vision plans selected by the Employer; or

    f. ☐ Other (Specify): ____

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19. The maximum dollar amount that a participant may contributed to his or her Dependent Care Benefit for a Plan Year is (Select a, b or c):

    a. ☐ N/A, b. ☐ $5,000 filing jointly/$2,500 filing separately or c. ☐ $_________ filing jointly or $________ filing separately.

20. Participants shall make Salary Reduction Contributions for this or her Dependent Care Benefit (Select a, b, c or d):

    a. ☐ Each payroll period, b. ☐ Every other payroll period, c. ☐ Once a month, or d. ☐ Other____

21. The minimum expense that the Dependent Care Flexible Spending Account will reimburse is (Select a, b, c, d or e): a. ☐ N/A, b. ☐ $50, c. ☐ $40, d. ☐ $30, or e. ☐ Other ____.

22. The maximum dollar amount that a participant may contributed to his or her PRA Benefit for a Plan Year is (Select a or b):

    a. ☐ N/A, b. ☐ $____________

23. The maximum dollar amount that the employer will contributed to an employees PRA Benefit for a Plan Year is (Select a or b):

    a. ☐ N/A, b. ☐ $____________

24. Change of Election: A participant may change his election for Salary Reduction Contributions up to ____________ times during the Plan Year.

25. A participant may change his or her benefit election for benefits, except for HSAs if the following events occur (Select all events that apply):

    a. ☐ Leaves of Absence, b. ☐ Change in Status, c. ☐ Change in Status-Other Requirements d. ☐ Special Enrollment Rights, e ☐ Certain Judgments, f. ☐ Medicare and Medicaid, g. ☐ Change in Cost., h ☐ Change in Coverage, i ☐ None of the above.

26. If a Participant changes his or her election during the Plan Year, such new election shall be effective (Select a, b, c, or d):

    a. ☐ the next pay period after the election is approved, b. ☐ the second to next pay period after the election is approved, c. ☐ 30 days after the election is approved, or d. ☐ Other ____.

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27. The runout period for all benefits shall be a period commencing (Select a, or b):

a. ☐ after the end of the Plan Year consisting of (Select i, ii, iii or iv): i ☐ two months, ii ☐ three months, iii ☐ four months, or iv ☐ Other (Specify): ______________, or b. ☐ after the end of the Plan Year and the grace period consisting of (Select i, ii, iii or iv): i ☐ two months, ii ☐ three months, iii ☐ four months, or iv ☐ Other ____,

28. If a participant terminates employment and then returns to employment within (Specify a, b, c or d):

a. ☐ two weeks, b. ☐ 30 days c. ☐ 60 days, or d. ☐ Other (Specify): ____________________________________, his or her benefits elections will return the same for the remainder of the Plan Year.

29. If a participant terminates employment during the Plan year, he or she may submit claims for reimbursement for a period after termination not exceeding (Select a, b. c or d):

a. ☐ 30 days, b. ☐ 60 days, c. ☐ 90 days or d. ☐ Other (Specify): ____.

30. If any Participant forfeitures are remaining after the end of the runout period for the Plan Year, such forfeitures shall be (Select a, b, c or d):

a. ☐ used to defray reasonable administrative expenses, b. ☐ used to reduce required premiums, c. ☐ used to increase the annual coverage amounts, or d ☐ returned to participants in the form of cash.

31. The Plan Administrator under the Plan shall be (Select a, b, c, or d):

a. ☐ The Employer sponsoring the Plan,

b. ☐ A committee appointed by the Employer,

c. ☐ An Individual (Specify) _______________________________________,or

d. ☐ Other: ____.

32. The Named Fiduciary under the plan shall be (Select a, b, or c):

a. ☐ The Employer, or b. ☐ Other (Specify): ____ .

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33. The Employer must provide an annual statement of benefits if to participants it offers Dependent Care Flexible Spending Accounts(Select a or b):

    a. ☐ N/A, the employer does offer these accounts, or b. ☐ The employers offers these account and such statement will be provided to participants by (Select I, ii iii, iv or v): i ☐ 2 weeks, ii ☐ 3 weeks, iii ☐ 4 weeks, iv ☐ five weeks, or v ☐ Other (Specify): ___________________________ after the end of the plan year.

34. Any benefit checks that are either remain unclaimed or uncashed shall be forfeited back to the employer if it remains unclaimed or uncashed for (Select a, b, or c):

    a. ☐ 210 days, b. ☐ 180 days, or c. ☐ Other __________________ after the check was issued.

35. Payroll deductions are:

    a. ☐ weekly b. ☐ bi-weekly c. ☐ monthly d. ☐ other______________

36. First payroll deductions will begin _________________________________
(date)

IN WITNESS HEREOF, the Employer has caused this Form to be completed by its duly authorized Officer on the date indicated below:

____
(Legal Name of Employer)

By:

____
(Signature & Title of Officer & Date)

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