

Section 125 Plan Design Checklist

1. Name of Employer: (exactly as it is to appear with punctuation)

- a. _____
b. _____

2. Employer's Address:

- a. _____
(Street--Physical and P.O. Box)
b. _____ c. _____ d. _____
(City) (State) (Zip)
e. Telephone () _____
f. E-mail Address _____

3. Employer's Federal Tax ID No: a. _____

4. Plan Information:

- a. New Plan
b. Amendment and Restatement

5. Plan Number (circle one): a. 501 502 503 504 _____

6. Employer Entity:

- a. S Corporation (2% shareholders not eligible)
b. Corporation
c. Partnership (self-employed (partners) not eligible)
d. Sole Proprietorship (self-employed not eligible)
e. Governmental Entity or Church
f. Non-Profit Organization
g. Limited Liability Company (member(s) not eligible)

7. Plan Name/Title of Document: (exactly as it is to appear with punctuation)

- a. _____
b. _____
c. _____

8. Plan Year (first day and last day in a twelve month complete Plan Year):

- a. Begins _____
(month) (day)
b. Ends _____
(month) (day)

Is first year a short Plan Year (less than twelve months)?

- c. Yes, beginning _____
(month) (day)
d. N/A

9. Effective Date(s):

- a. Initial Effective Date _____
(month) (day) (year)
b. Amendment/Restatement _____
(month) (day) (year)

10. Eligible Class of Employees:

- a. All Employees who satisfy eligibility requirements
b. Salaried Employees only
c. Hourly Employees only
d. All Employees except:
1. Commissioned Employees
2. Union Employees
3. Leased Employees
4. Part-time Employees, expected to work less than _____ hours per week
5. Nonresident Aliens
6. Other _____

11. Conditions for Eligibility:

- a. Same as Employer's group medical plan (skip to 12)
OR
b. For first Plan Year only, anyone employed on the effective date of the Plan is eligible, thereafter:
(Choose one from d-g below)
OR
c. For all years, eligibility is as follows:
(Choose one from d-g below)
d. Date of hire (no service required)
e. _____ years after date of hire
f. _____ days after date of hire
g. _____ months after date of hire

12. For Medical Reimbursement Plan only, eligibility is as follows:

- a. No Medical Reimbursement Plan (skip to 13)
b. Eligibility is the same as above for all benefits
c. _____ days after date of hire
d. _____ months after date of hire
e. _____ years after date of hire

Note: If option b., c., d., or e. selected, 19 b., c., or d. must also be selected.

13. Entry Date (Effective Date of Participation):

- a. First day of the pay period following date requirements were met
b. Date conditions for eligibility are met
c. Dual entry (1st day of Plan Year & 6 months later)
d. First day of Plan Year following date requirements were met
e. First day of month following date requirements were met
f. Same as Employer's group medical plan

14. Compensation received during Plan Year shall be...

- a. Total cash remuneration
b. Base compensation (excludes overtime, commissions and bonuses)
c. Other _____
d. N/A

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15. Premium Payments (employer billed) may be elected for...

- a. N/A-Premium Payments (employer billed) are not offered (skip to 16)
- b. Health insurance \$ _____/Mo (individual AND dependent coverage)

OR

- c. No group health insurance

AND

- d. Group-term life insurance \$ _____/Mo
- e. Disability insurance \$ _____/Mo
- f. Dental insurance \$ _____/Mo
- g. Cancer insurance \$ _____/Mo
- h. Vision insurance \$ _____/Mo
- i. Accident Insurance \$ _____/Mo
- j. Other _____ \$ _____/Mo
- k. Other _____ \$ _____/Mo

16. Are the health premium payments elected above self-insured by the Employer?

- a. Yes
- b. No

17. Is automatic enrollment for insured benefits provided under this Plan?

- a. Yes
- b. No
- c. N/A-Insured benefits are not offered (answer 18a, then skip to 19)

18. Benefit Limitations: (select as applicable):

- a. N/A--No limitations (skip to 19)
- b. Group-term life insurance premiums needed to purchase:
 - 1. _____ times compensation
 - 2. \$50,000
 - 3. lesser of _____ times compensation or \$50,000
 - 4. N/A

Note: Term Life Insurance over \$50,000 could result in taxation to Employees.

c. Disability shall be limited to _____% of compensation.

Note: If limitations are not selected, Policy will control.

19. Flexible Spending Accounts will be established for...

(select from the list below and designate limits as applicable):

- a. N/A-Flexible Spending Accounts are not offered (skip to 20)
- b. **General-Purpose Medical Reimbursement**
Limit: \$ _____/Plan Year
- c. **Limited-Purpose Medical Reimbursement (HSA Compatible)**
Limit: \$ _____/Plan Year
- d. **Post-HSA Deductible Medical Reimbursement (HSA Compatible)**
Limit \$ _____/Plan Year
- e. **Dependent Care Reimbursement**
- f. **Individual Premium Reimbursement** (Allow reimbursement of individual health or health related policies through the Premium Conversion Plan.)

20. Health Savings Account (HSA) Component will be established for HSA contributions (select as applicable):

- a. N/A-HSA Component is not offered (skip to 21)
- b. Yes
 - 1. Employee only contributions to HSA
 - 2. Employee and Employer contributions to HSA

21. Contributions. Flexible Benefit Plan will provide for...

- a. Salary reduction contributions **ONLY**
(no Employer contributions) (answer 22a, then skip to 23)
- b. Employer contributions **ONLY**
(no salary reductions) (answer 22, then skip to 23)
- c. Both salary reductions **AND** Employer contributions

22. Employer Contributions. For each Plan Year, Employer will contribute...

- a. N/A-Employer contributions are not available (skip to 23)
- b. _____% of compensation per Participant
- c. _____% matching contributions, up to a maximum of \$ _____ per _____ (frequency) per Participant
- d. \$ _____ per Participant (same for all participants)

OR

(Complete 1-3 if applicable, otherwise skip to 22f.)

- 1. \$ _____ per Single Participant
- 2. \$ _____ per Limited Family Participant
- 3. \$ _____ per Family Participant

- e. Other _____

AND, the contributions shall be made...

- f. Lump Sum at beginning of the Plan Year
Prorated for new hires?
 - 1. Yes, explain _____
 - 2. No
- g. Lump Sum at beginning of the Month
- h. Lump Sum at end of the Month
- i. Pro rata each pay period

AND, the employer contributions can be used as follows:

(Check as applicable)

- j. **Any eligible Flexible Benefit Plan Option(s)**
- k. **Flexible Spending Accounts**
(except Individual Premium Reimbursement)
- l. **Premiums available through the Employer**
(Do not select this option if employer contributions are required under a group health insurance contract only.)
- m. **Health Savings Account (HSA)**
 - 1. All HSA Participants
 - 2. Participants of Employer Sponsored HDHP Only
- n. **Other Restrictions or Specifications** (please describe):

AND, the employer contributions are convertible to cash

- o. Yes
- p. No

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23. Salary Reduction Election. For each Plan Year Employees may elect to reduce compensation by...

- a. Amounts sufficient to support benefits elected

AND

Highest Insurance Premium \$ _____/mo

X _____ 12

Annual Premium \$ _____

X _____ 2

Annual Premium Inflated \$ _____

Plus Medical FSA Limit \$ _____

Plus Dependent Care Limit \$ _____

Plus HSA Limit \$ _____

Total Plan Limit* \$ _____

(*Record Total Plan Limit on Line 23b. below)

- b. Up to \$ _____ each Plan Year*

Note: Regulations require the Plan Document to state either a maximum or formula for determining such.

24. Change of Election/Status permitted within...

- a. Yes (Choose 1 or 2 below)

1. 30 days of the qualifying event

2. 60 days of the qualifying event

- b. No

c. Other _____

If adopted, HSA Component is not subject to Change of Status rules.

25. Benefit Election Period for Open Enrollment shall be the...

- a. 30 day period prior to each Plan Year

- b. 60 day period prior to each Plan Year

- c. Other _____

26. Participants who fail to sign a new election form shall...

- a. Continue same elections as prior year for all benefit options elected.

- b. Be considered to have elected not to participate for all benefit options upcoming Plan Year.

- c. Continue same elections as prior year only for insured benefits and HSA contributions (if applicable) and be considered not to have participated in flexible spending accounts for upcoming Plan Year.

27. Any forfeited amounts shall be:

- a. Retained by the Employer

- b. Distributed to Participants per capita

If adopted, the HSA Component is not subject to forfeiture.

28. For the Medical Reimbursement Plan, terminated Employees shall...

- a. Cease contributions and reimbursements upon termination

(Unless electing COBRA as applicable to the plan)

- b. N/A--Medical Reimbursement Plan is not offered

29. For the Medical Reimbursement Plan only, the 2 ½ month grace period will apply:

- a. Yes

- b. No

- c. N/A--Medical Reimbursement Plan is not offered

30. Claims for Reimbursement must be filed within...

- a. 60 days following each Plan Year

- b. _____ days following each Plan Year (e.g., 60)

- c. N/A--Flexible Spending Accounts are not offered

Except, if the grace period for the Medical Reimbursement Plan is adopted, claims for Medical Reimbursement must be filed by the last day of the first full month following the expiration of the grace period.

31. Plan Administrator shall be:

- a. Employer, using Employer's address

OR

- b. Other

(Name)

AND, if Other selected

- c. Use address below...

1. _____

(Street--Physical not P.O. Box)

2. _____ 3. _____ 4. _____

(City)

(State)

(Zip)

32. Plan's Agent for service of legal process is:

- a. Employer, using Employer's address

33. Employer's Principal Office:

- a. _____

(List State)

34. Will Affiliated Employers execute this Plan?

- a. N/A or No (skip to 35)

- b. Yes, include additional signature lines as follows: **OR**

- c. Include Board of Directors Resolutions as follows (so that Affiliated Employers may adopt the flexible benefit plan named in 7 a, b, and c):

1. _____

(Company Name)

2. _____

(Street)

3. _____

(City)

(State)

(Zip)

4. _____

(Federal ID No.)

1. _____

(Company Name)

2. _____

(Street)

3. _____

(City)

(State)

(Zip)

4. _____

(Federal ID No.)

Note: If more than 2 affiliated companies, record additional information under question #36 at the end of this checklist.

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35. Witnesses to Employer's signature:

a. Yes _____
List Name(s) as applicable

Record number of signature lines required _____

(Answer yes, only if more than one person is required to execute the legal documents and contracts associated with this Flexible Benefit Plan.)

b. No

Note: State law may require witnesses to the Employer's signature.

36. Other Plan Specifications (describe below):

a. Yes _____

b. N/A

37. Person authorized to act on behalf of the Plan:

a. _____
Print Name

b. _____
Title

38. If different, person to contact for routine information:

a. _____
Print Name

b. _____
Title

I understand that Benefits Design Group, Inc. will prepare plan documents using a format developed by Benefits Design Group, Inc., that is based on the information that I have provided on this plan design checklist. Any changes made to the plan design after this form is submitted for processing may result in additional plan document charges. I understand that the Employer is responsible for reviewing and approving the plan documents that Benefits Design Group, Inc. provides. I understand that the Employer is responsible for designing, maintaining and operating the plan consistent with applicable laws. **The Employer agrees to pay Benefits Design Group, Inc. for the completed plan documents upon receipt, at the prices in effect at that time.**

Authorized Employer Representative _____ Title _____
Please Print

Signed _____ Date _____
Employer Signature Required

Return completed and signed form to:

**Benefits Design Group, Inc.
PO Box 370
Onalaska WI 54650
1-800-342-8235 or 1-800-554-7213
(608) 781-4576**

By fax to: