PLAN SET UP
SECTION 125 ACCOUNT

Employer/Plan Sponsor:

Legal name:_____ TIN:_____

Address:_____

Phone:_____ Fax #:_____

Main Contact_____ Email Address_____

Divisions: _____

Number of Employees:_____

Eligibility Requirements:

Hours worked:_____ per_____ Waiting period:_____

Effective Date: First Date Following Completion of Waiting Period _____
First of the month following completion of the Waiting Period_____

Plan Information:

Effective date:_____ Plan year:_____

Plan includes: ☐ Dependent Care ☐ Medical Reimbursement
☐ Premium ☐ Transportation
If premium: ☐ Medical ☐ Dental
☐ Other_____

Employer Contributions:$_____

Maximum Employee Contribution (FSA):$_____

Payroll Frequency: Weekly_____Bi-Weekly 26_____ Bi-Weekly 24 _____Monthly _____Other _____

Date of first pay period_____

☐ $500 Rollover allowance
OR
☐ Grace period: ☐ Yes If yes, length of grace period_____
(maximum 2 ½ months)
☐ No

Run-out period:_____days

Plan that pays first (if applicable): ☐ FSA ☐ HRA

Medical Plan Details: Please Attach a copy of the Schedule of Benefits for Your Plan