

**PACIFIC BENEFIT CONSULTANTS, INC.**  
**Confidential Client Information for Documents**

For office use only:  
 Full FSA  
 Full POP  
 "10" FSA  
 "10" POP  
Ref. By: \_\_\_\_\_

**Proposed Cafeteria Plan Year: From \_\_\_\_\_ to \_\_\_\_\_**  
(Must Be a Twelve (12) Month Period Unless Other Arrangements Have Been Made)

1. **Exact Name of Company:** \_\_\_\_\_

**Mailing Address** (Also Street Address, if different): \_\_\_\_\_  
\_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Extension: \_\_\_\_\_

Employer Benefits Coordinator and Title: \_\_\_\_\_

Name and Title of Document Signer: \_\_\_\_\_

2. **Federal I.D. Number:** \_\_\_\_\_ **Date Organized:** \_\_\_\_\_

**Organization Type (Circle One):**  
(Corp., Sub-S Corp., Partnership, LLC, Proprietorship, Non-Profit, Gov. Agency, Other)

**Business Activity Code(SIC #):** \_\_\_\_\_ **State of Origin:** \_\_\_\_\_

**Nature of Business:** \_\_\_\_\_

3. **Plan Information:**

**Circle Type of Payroll(s)**

Weekly (48, 52), Bi-weekly (26), Bi-Weekly (24), Semi-Monthly, (24) Monthly (date), Other \_\_\_\_\_

**Date of First Payroll for Pre-tax Benefits to Start in Plan Year:** \_\_\_\_\_

**Service Period Requirement (30, 60, 90 days, etc.):** \_\_\_\_\_

*Initial Plan Year or All Plan Years:* \_\_\_\_\_

**Entry Date (First of Month, First Pay Date, etc.):** \_\_\_\_\_

**Hours Per Week to Qualify For Benefits:** \_\_\_\_\_ **Minimum Age** \_\_\_\_\_

**Seasonal Employees Hours to Qualify:** \_\_\_\_\_ **Union Employees Eligible (Y) (N)**

4. **Benefits:**

**Core Medical Insurance:** (Y) (N)

**Non-core Medical Insurance:** (Y) (N)

Types: \_\_\_\_\_

**Supplemental Medical Insurance:** (Y) (N)

Types: \_\_\_\_\_

**Dependent Care Assistance Benefit:** (Y) (N)

**Out-of-Pocket Health Expense Benefit:** (Y) (N)

Annual Dollar Limit: \_\_\_\_\_

**Individually Owned Insurance Benefit:** (Y) (N)

Must Be A Health Insurance Policy

**Spending Credit:** \_\_\_\_\_ **Per Pay Period/Year**

**Reimbursement Method:**

Check To Employer For Disbursement

Check Mailed To Employee Home

Direct Deposit

Check Edit

Laser Signature

Not Applicable

**THE ABOVE INFORMATION IS BEING PROVIDED WITH THE INTENT OF ESTABLISHING A SECTION 125 CAFETERIA PLAN WITH PACIFIC BENEFIT CONSULTANTS BEING THE CONTRACT ADMINISTRATOR**

\_\_\_\_\_  
SIGNATURE AND TITLE

\_\_\_\_\_  
DATE