



Confidential Client Information for Documents

For office use only: Full FSA
 Full POP "10" FSA
 "10" POP

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

1. Exact Name of Company: (list all affiliated companies)

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, Proprietorship, Non-Profit, Gov. Agency, LLC, Other)

Business Activity Code (SIC #): _____ State of Origin: _____

Nature of Business: _____

3. Plan Information: Circle Type of Payroll(s)
 Weekly (48), Weekly (52), Bi-wkly (26), Bi-Wkly (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: _____

Service Period for FSA Med (if different): _____

Entry Date (First of Month, First Pay Date, etc.): _____

Hours per Week to Qualify For Benefits: _____ **Minimum Age** _____

Terminated Employees Claim Submission Grace Period ends # _____ **Days after date of termination**

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

4. Benefits:

Core Medical Insurance: (Y) (N) **Tracking:** Pay period info. _____ Semi-annual info. _____

Non-core Medical Insurance: (Y) (N)
 Dental _____ Vision _____ Other _____

Supplemental Medical Insurance: (Y) (N)
 AFLAC _____ Other _____

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

5. Reimbursement Method: Direct Deposit, Electronic Payroll, Debit Card
 Laser Signature _____ Checks to EE's homes _____ Checks to ER (Default) _____

6. IRS 2.5 month "grace period" for Health Care and Dependent Care Spending Account: Yes / No
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