



Premium Only Plans
Confidential Client Information Sheet

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 (will align with existing benefit policies)

Hours Per Week to Qualify For Benefits: _____ Minimum Age _____

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

4. Benefits to Include:

Core Medical Insurance (Group Insurance) Check One: ___ Fully Insured / ___ Self Insured

Non-core Medical Insurance (Dental, Vision, Other)

Supplemental Medical Insurance: (AFLAC, Etc.)

HSA Language

THE ABOVE INFORMATION IS BEING PROVIDED WITH THE INTENT OF ESTABLISHING A SECTION 125 CAFETERIA PLAN WITH PACIFIC BENEFIT CONSULTANTS PROVIDING DOCUMENT ONLY SERVICES.

SIGNATURE AND TITLE

DATE