



CA LIC# 0708953
P.O. Box 7809 ~ Visalia, CA 93290
(559) 733-1240 FAX (559) 733-2325

SECTION 125 EMPLOYER APPLICATION

GENERAL INFORMATION:

Legal Name of Organization: _____

Street Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Phone: () _____ Fax: () _____ Email: _____

Plan Contact: _____ Title: _____

Total Number of Employees: _____

PLAN DOCUMENT INFORMATION:

Federal Tax ID No: _____ Plan No: _____ (501 will be assigned unless indicated otherwise)

TYPE OF ORGANIZATION:

- | | |
|--|--|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Partnership (NOTE: Partners may not participate) |
| <input type="checkbox"/> Sub-Chapter "S" (NOTE: Shareholder may not participate) | <input type="checkbox"/> Sole Proprietorship (NOTE: Owner may not participate) |
| <input type="checkbox"/> LLC (NOTE: Partners may not participate) | <input type="checkbox"/> Government Agency |

Date incorporated or date organization started: Mo _____ Day _____ Year _____

Nature of Business: _____ IRS Business Activity Code _____

First Plan Year Begins: _____ Ends: _____ Do you currently have a Section 125 Plan ? _____

Individual Who Will Sign Plan Documents: _____ Title: _____

Legal Contact: _____ Title: _____

Address: _____ City: _____ Zip: _____

PAYROLL INFORMATION:

PAYDATES: (Note: Please list date of check, not payroll ending date)

- | | |
|---|---|
| <input type="checkbox"/> Weekly – What day of the week? _____ | <input type="checkbox"/> Bi-Weekly -- What day of the week? _____ |
| <input type="checkbox"/> Semi-monthly – What dates? _____ | <input type="checkbox"/> Monthly – What date? _____ |

What will be the first paydate pre-tax withholdings will begin: _____ (Note: Cannot begin prior to Plan effective date)

Contributions will be withheld: _____ Each Paycheck _____ Other _____

BENEFIT INFORMATION:

_____ Premium Conversion Plan Only _____ Premium and Flexible Spending Arrangement

If FSA, plan will include:

_____ Unreimbursed Medical Expenses Annual Dollar Maximum _____ (Mandatory)

_____ Dependent Care _____ Individual Plan Premium Reimbursement

Do you want to include a 2 ½ month claim grace period? Yes _____ No _____

Group Medical Carrier _____ Group Policy No. _____

Group Dental Carrier: _____ Group Policy No. _____

Group Vision Carrier _____ Group Policy No: _____

Supplemental Plan Carrier: _____

Health Savings Account _____

Other: _____

ELIGIBILITY GUIDELINES: All areas must be completed

_____ All Employees _____ Salary Only Employees _____ Hourly Only Employees

All areas must be completed

Not Eligible, if age under _____ years.

Not Eligible, if works less than _____ hours per week.

Not Eligible, if employed less than _____ months per year (ie seasonal employees)

Are Union employees eligible Yes _____ No _____ N/A _____

Other _____

New Employee Waiting Period: _____ (this generally follows the same guidelines as your group policy(s).

Identify the following:

Owners	Officers	Partners

ADDITIONAL INFORMATION:

Application Completed by:

Signature

Date

SECTION 125 PLAN

ADMINISTRATION PROVIDED BY:



CA LIC# 0708953

P.O. BOX 7809

VISALIA, CA 93290

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Employer Application:

In order to provide you with accurate legal documentation for your Section 125 plan it is essential that you complete all areas on the attached employer application.

Employee Applications:

In order to perform the discrimination testing required of a Section 125 plan it is essential that all areas of the Section 125 Election Agreement be completed.

It is important that your employees read and understand their Section 125 Election Agreement. IRS guidelines stipulate that once an employee has elected to participate in a Section 125 plan, they may not change, add or terminate their election during the plan year unless that change, addition or termination is due to a change in family status or a carrier rate change.

Thank you for the confidence you have placed in us by allowing us to administer your Section 125 plan. If you have any questions while completing these applications, please give us a call, we will be happy to assist you.

Contributions:

Please include a voided check from the checking account from which you will pay reimbursements. Please indicate the check number sequence you would like us to use.