

PREMIUM ONLY PLAN INFORMATION FORM

Name of Plan Sponsor (Company) _____

Address _____

City, State, Zip _____

Principal _____ Title _____

Telephone (_____) _____ Ext _____ Fax (_____) _____

E-mail Address _____ Employer Fed Tax ID # _____

Form of Organization _____ Date of Incorporation _____

Principal Business Activity _____ Under Laws of (State) _____

Affiliated Employers (if any): _____

Effective Date of Plan (New Plan) _____ Effective Date of Original Plan if
this is an Amendment or Restatement of a Previously Established Plan _____

Start Date for this Plan Year _____ End Date _____

Tax Year Start Date _____ End Date _____

Who Will be the Administrator of this Plan? _____

Title _____ Telephone (_____) _____ Ext _____

Fax (_____) _____ E-mail _____

Eligibility Waiting Period _____ Minimum Age _____ Minimum Hours per Week _____

**American Benefits Group and its employees are not engaged in the
practice of law and do not provide legal advice or consultation.**

Please return this completed form to :

**American Benefits Group
P.O. Box 1209
Northampton, MA 01061-1209**

**Tel: 800-499-FLEX (800-499-3539)
Fax: 866-EZE-FLEX (866-393-3539)
Website: www.myFlexResource.com**