AMERICAN BENEFITS GROUP

PREMIUM ONLY PLAN (POP) COMPLIANCE SOLUTION
CLIENT INFORMATION FORM

Includes Plan Document, yearly restatements of the Plan Document (as needed) and annual Non-discrimination testing

Company Information

Name of Plan Sponsor (Company): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Executive Officer: _____ Title: _____

Telephone:_____ Email Address: _____

Type of Organization: Choose State of Organization: _____

Employer Fed Tax ID#: _____ State of Main Office: _____

State of Governing Law: _____

Are there any affiliate companies of the plan sponsor?

Do employees of an entity with a different EIN thant the employer's EIN participate in this Plan? ☐ Yes ☐ No

If yes, please complete the Affiliates Questionnaire linked here download affiliates questionnaire

Who will be the Administrator of this Plan? _____

Title: _____ Telephone:_____

Fax: _____ Email Address: _____

Invoice Contact _____ Email: _____

The POP Documents will be created and sent to you once payment has been received and cleared, the POP Annual Compliance Subscription Cost is $395.

Plan Information

Is this Plan new or a Restatement? New

Start Date for this Plan Year: End Date:

Original Effective Date (only if Restatement):

Amended and Restated Date (only if Restatemet):

Short Plan Year?

Renewal Year Start (only if short Plan year): Renewal Year End (only if short Plan Year)

Plan Benefits

Check all which apply (You may not permit pre-tax payroll deductions unless the benefit is inluded inyour POP)

Group Medical Insurance	☐	Long-Term Disability Insurance	☐
Group Dental Insurance	☐	Short-Term Disability Insurance	☐
Group Vision Insurance	☐	Accidental Death and Dismemberment Insurance	☐
HSA Contributions	☐	Critical Illness Insurance	☐
Group Term Life 11 Cancer	☐	Hospital Indemnity Insurance	☐
Insurance Voluntary	☐	Cash In Lieu of Benefits	☐
Benefits Personal Sickness	☐	Intensive Care Insurance	☐
Indemnity	☐	Specified Health Event	☐

Eligibility Wait Period:

Employee Elections Choose

Include Participant Election Forms Choose

Allow Change of Status if employee Full-Time status drops below 30 hours? Choose

Allow Change of Status if employee is eligible for a Special Enrollment or Annual Open Enrollment Period in a qualified Health Plan within a Marketplace? Choose

Include FMLA Language? Choose

Employer intends this Plan to qualify as a “Simple Cafeteria Plan” for purposes of Code Section 125(j): Choose

Employer uses “Top-Paid Group” Election for 401(k) Nondiscrimination Testing purposes: Choose

Please return this completed form to:

American Benefits Group
PO Box 1209
Northampton, MA 01061-1209

Tel: 800-499-3539
Fax: 877-723-0147
email: implementation@amben.com

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