



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 Nondiscrimination Testing**

**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.**

Company Profile

Name of Plan Sponsor (Company): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Executive Officer: _____ Title: _____

Telephone: _____ Email Address: _____

Type of Organization: _____ Under Laws of (State): _____

Employer Fed Tax ID#: _____ Date of Incorporation: _____

Employers (if any): _____

Who will be the Administrator of this Plan? _____

Title: _____ Telephone: _____

Fax: _____ Email Address: _____

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

If yes, please complete the Affiliates Questionnaire linked here [download affiliates questionnaire](#)

POP Plan Details

What is the 3 digit ERISA plan number associated with your Section 125 Plan? 501 Other _____

Original Plan Effective Date: _____ Effective Date of Amendment: _____

Start Date for this Plan Year: _____ End Date: _____

Short Plan Year?

Renewal Year Start (only if short plan year): _____ Renewal Year End (only if short plan year): _____

Participation in the Plan Begins (please check):

- As of date of hire
- From date of hire: 30 days 60 days 90 days Other _____
- First of the month following: DOH 30 days 60 days 90 days Other _____
- Other (please explain): _____

Minimum Hours per Week required for benefit eligibility: _____

Coverage Ends:

End of the Month

Date of Termination or Loss of Coverage

Please check the benefits to be included under your Section 125 Cafeteria Plan:

You may not permit pre-tax payroll deductions unless the benefit is included in you POP)

- | | |
|--|---|
| <input type="checkbox"/> Group Medical Insurance | <input type="checkbox"/> Long-Term Disability Insurance |
| <input type="checkbox"/> Group Dental Insurance | <input type="checkbox"/> Short-Term Disability Insurance |
| <input type="checkbox"/> Group Vision Insurance | <input type="checkbox"/> Accidental Death and Dismemberment Insurance |
| <input type="checkbox"/> Health Savings Accounts (HSA) | <input type="checkbox"/> Critical Illness Insurance |
| <input type="checkbox"/> Group Term Life Cancer | <input type="checkbox"/> Hospital Indemnity Insurance |
| <input type="checkbox"/> Cash In Lieu of Benefits | <input type="checkbox"/> Intensive Care Insurance |
| <input type="checkbox"/> Special Health Event _____ | |
| <input type="checkbox"/> Other _____ | |

Employer intends this Plan to qualify as a "Simple Cafeteria Plan" for purposes of Code Section 125(j): Yes No

[What is a Simple Cafeteria Plan?](#)

Employer uses "Top-Paid Group" Election for 401(k) Nondiscrimination Testing purposes: Yes No

Please return this completed form to: implemenation@amben.com

Contact: _____ Title: _____

Authorized Signature: _____ Date: _____

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