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: _____

Broker Contact: _____ Email Address: _____

Executive Officer: _____ Title: _____

Plan Administrator: _____ Title: _____

Telephone: _____ Email Address: _____

Type of Incorporation *(please check):*

☐ Non-Profit Organization ☐ Government Agency

☐ Partnership* ☐ Sole Proprietorship* ☐ LLC *(Limited Liability Company)**

☐ Sub-chapter "C" Corporation ☐ Sub-chapter "S" Corporation* ☐ Other _____

* **Note**: Subchapter S Corporation shareholders above the 2% level **may not** participate, but they may sponsor a plan for their employees. In addition, family members and close relatives of these shareholders **may not** participate. LLC, LLP and Sole Proprietors **may not** participate, but may sponsor a plan for their employees. However, if the spouse is a bona fide employee of the firm, he or she may participate and use the benefit for the entire family.

Under Laws of (State): _____ Employer Fed Tax ID#: _____ Date of Incorporation: _____

Affiliated Employers *(if any):* _____

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: _____

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 (please explain): _____

☐ First of the month following: ☐ DOH ☐ 30 days ☐ 60 days ☐ 90 days ☐ 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 your POP:

- ☐ Group Medical Insurance
- ☐ Group Dental Insurance
- ☐ Group Vision Insurance
- ☐ Health Savings Accounts (HSA)
- ☐ Group Term Life Cancer
- ☐ Cash In Lieu of Benefits
- ☐ Long-Term Disability Insurance
- ☐ Short-Term Disability Insurance
- ☐ Accidental Death and Dismemberment Insurance
- ☐ Critical Illness Insurance
- ☐ Hospital Indemnity Insurance
- ☐ Intensive Care Insurance
- ☐ Special Health Event _____
- ☐ 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: implementation@amben.com

Who is your COBRA Administrator? _____

Printed Name: _____ 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.