

New Plan

Plan Begin Date: _____ Plan End Date: _____

Amended & Restated

Effective Date of Amended/Restated Plan: _____

Plan Effective Date: _____ Short Plan Year: ___Y ___N

EMPLOYER INFORMATION DATA FOR SECTION 125 PLAN SETUP

Type of Plan filing for: _____ Flexible Spending Account _____ Flex Dollars _____ Premium Pass Only

Do you currently have an HSA in place? _____ YES _____ NO

Business Name: _____

Type of Company: ___ Sole Proprietor ___ Partnership ___ C Corp ___ S Corp ___ LLC ___ Gov't Entity or Church

Company Federal ID#: _____ Approximate # of Employees: _____

Company Contact Person: _____ Contact Email Address: _____

Company Address: _____ City: _____ State: _____ Zip: _____

Contact Phone Number: _____ Contact Fax Number: _____

Eligible Class of Employees:

- All employees
- All employees EXCEPT:
 - Employees not eligible for group medical plan
 - Employees working less than ___ hours/months Per week/year.
 - Other: _____

Unreimbursed Medical Limit: \$ _____

Reverse Election: _____ YES _____ NO

Administrative Fee: \$ _____ per month = \$ _____ per pay period

Fee Paid by: _____ Employer _____ Employee

Conditions for Eligibility:

- Same as Employer's Group Medical Plan: _____
- Date of Hire (no service required)
- _____ days after date of hire
- _____ months after date of hire

of Employee Reimbursements per year:

_____ 24 _____ 26 _____ 52

Number of Pay Periods per year: _____

Separate eligibility requirements for Unreimbursed Medical Only? _____ YES _____ NO

If yes: please explain: _____

Initial Plan Year Pay Period Dates:

January _____	July _____
February _____	August _____
March _____	September _____
April _____	October _____
May _____	November _____
June _____	December _____

Plan Entry Date:

- First day of pay period next following date requirements Were met
- First day of month following date requirements were met
- Date conditions of eligibility were met
- Same as Employer's group medical plan

Submitting Agent: _____

Submitting Agent Phone: _____

REIMBURSEMENT OPTIONS : _____ Checks _____ Direct Deposits _____ Debit Cards(additional fees apply)

Return Completed form to:

SECURE BENEFITS SYSTEMS
P.O. Box 469, Okoboji, IA 51355 or FAX: 800.421.6737

Questions? 800.562.8454