**Cafeteria Plan Document Information Please complete or check all applicable blue items**

**Company Information:**

**1.** Name of adopting employer or Plan Sponsor: Plan Sponsor or lead Employer name

**2a.** Address line 1: Street address of PO Box

**2b.** Address line 2: Suite number

**3.** City: City **4.** State: State **5.** Zip: Zip

**6.** Phone: Area Code AC Number Fax: Area Code AC Number

**Additional Company Information:**

**8.** Plan Sponsor EIN: Tax ID number **9. F**iscal year end: Month Day, Year

**10a.** Entity type:

 [ ] C Corporation [ ] S Corporation [ ] Non-profit [ ] Partnership [ ] Limited Liability Company

[ ] Limited Liability Partnership [ ] Sole Proprietorship [ ] Union [ ] Government agency [ ] Other

**10b.** If **10a** is "Union", enter name of the representative of the parties who established or maintain the Plan:

 Union, local number or representatives

**10c.** If **10a** is "Other", enter Plan Sponsor entity type: Type of organization

**11.** State of organization of Plan Sponsor: State

**12a.** The Plan Sponsor is a member of an affiliated service group: [ ] Yes [ ] No

**12b.** If **12a** is "Yes", list name & EIN of all other members of the group:

 EIN 1 Name 1

 EIN 2 Name 2

 EIN 3 Name 3

**13a.** Is the Plan Sponsor a member of a controlled group: [ ]  Yes [ ]  No

**13b.** If **13a** is "Yes", list name & EIN of all other members of the group:

 EIN 1 Name 1

 EIN 2 Name 2

 EIN 3 Name 3

 **Contact Information:**

**21.**  Salutation Name Title

 Phone AC Phone number Fax AC Fax number

 Email

**B. General Plan Information:**

**1.** Plan Number: \_ \_ \_ **2.** Plan name: ERISA plan name

**3a.** Original effective date of Plan: Month Day, Year

**3b.** Restatement of a previous plan? [ ] Yes [ ]  No **3c.** If "Yes", effective date: Month Day, Year

**4a.** Plan Year End: Month Day, Year

**4b.** The Plan has a short plan year: [ ] Yes [ ] No

**4c.** If “Yes", start date: Month Day, Year **4d.** end date: Month Day, Year

**B. Plan Features:**

**1.** [ ] **Yes** [ ] **No** Contributions to fund a Premium Conversion Account are permitted:. If yes, contributions permitted to pay premiums for:

[ ] **Yes** [ ] **No** Employer Group Medical coverage

[ ] **Yes** [ ] **No** Employer Dental coverage

[ ] **Yes** [ ] **No** Employer Vision coverage

[ ] **Yes** [ ] **No** Employer Disability coverage

[ ] **Yes** [ ] **No** Employer Group Term Life coverage

[ ] **Yes** [ ] **No** Individually-owned medical coverage

[ ] **Yes** [ ] **No** Individually-owned Dental coverage

[ ] **Yes** [ ] **No** Individually-owned Vision coverage

[ ] **Yes** [ ] **No** Individually-owned Disability coverage

[ ] **Yes** [ ] **No** Other coverage: (if “Yes”, describe: Description of other coverage

**2.** [ ] **Yes** [ ] **No** Contributions to fund a Healthcare Reimbursement Account (FSA) are permitted.

**3.** [ ] **Yes** [ ] **No** Contributions to fund an HSA Account are permitted (Section 4.08):

**4.** [ ] **Yes** [ ] **No** Contributions to fund a Dependent Care Assistance Account are permitted:

**5.** [ ] **Yes** [ ] **No** Contributions to fund a Adoption Assistance Account are permitted:

**6.** [ ] **Yes** [ ] **No** Is this a Simple Cafeteria Plan?

**C. Eligibility:**

**1a.** The following employees are EXCLUDED from coverage

[ ] Subject to a collectively bargained agreement

[ ] Leased employees

[ ] Non-Resident Aliens

[ ] Part-time employees working less than \_\_\_\_\_ hours per week

[ ] Other Other excluded coverage

**2.** Allow immediate participation for all Eligible Employees employed on a certain date?

[ ] No[ ] Yes, as of the Effective Date[ ] Yes, as of Month Day, Year

**3.** An Eligible Employee shall become eligible to be a participant in the Premium Conversion Plan at the same date he/she becomes eligible to participate in the Insurance Contract? [ ]  Yes [ ]  No

**4.** The minimum age for Eligibility is [ ]  None [ ]  21 [ ]  20½ [ ]  19 [ ]  18

**5.** The minimum service requirement for Eligibility is”

[ ] None

 [ ] hours of services

[ ] days of service

[ ] months of service

[ ] years of service

**6.** Entry Date is:

 [ ]  Immediate

[ ] Next following or [ ] Coincident with or next following:

[ ] First day of the month

[ ] First day of the Plan quarter

[ ] First day of the Plan Year

[ ] First day of the first and seventh months of the Plan Year

**7.** Other: Other limitation to age or service requirements

**8.** Permit Participants who are no longer Eligible Employees (for reasons other than Termination) to continue to participate in the Plan until the end of the Plan Year: [ ] Yes [ ] No

**9**. Automatically reinstate benefit elections for Terminated Participants who are rehired within 30 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 30 days after Termination: [ ] Yes [ ] No

**D. Benefits:**

**1.** Provide for automatic enrollment in the Premium Conversion Account?[ ] Yes [ ] No

**2.** Provide for automatic adjustment in POP elections for changes in the cost of contracts?[ ] Yes [ ] No

**3.** If Healthcare Reimbursement Accounts (FSA’s) are permitted:

 **a**. The maximum salary reduction is[ ] maximum permitted by law, or [ ] Other $ Amount

 **b**. Participants may continue making contributions for the remainder of the Plan Year after termination of employment? [ ] Yes [ ] No

 **c**. Participants may revise FSA elections [ ] withoutlimitation [ ] Increase only [ ] Not less than amount already reimbursed [ ] Other Description

 **d.** Allowable benefits are [ ] Group Health Coverage and Maximum Benefit[ ] Limited Scope [ ] Other: Description

 **e.** [ ] Specific expenses excluded \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **f.** Expenses may be reimbursed for [ ] Participant [ ] Participant, Spouse & dependents[ ] persons covered under group medical plan Name of plan(S)[ ] Other Description

 **g.** Coordination with HSA’s [ ] None [ ] Permitted Coverage [ ] Post Deductible Coverage [ ] Both

 **h.** Method of HRA coordination [ ] None [ ] HRA first [ ] Cafeteria plan first

 **i.** Company contributions [ ] None[ ] Company’s sole discretion [ ] 2% of Compensation [ ] Other:  Description

 **j.** Cash in lieu of benefits available?[ ] Yes [ ] No[ ] Yes, with limitation Describe limitiation

**E. Elections:**

**1. C**ontinuing Participants may make an election [ ] Pursuant toPlan Administrator Procedures[ ] Prior to beginning of the Plan Year

**2.** The election for a continuing Participant who fails to make an election in open enrollment shall be:

[ ] Election not to participate[ ] Continue same election [ ] Continue same POP election

**3.** When may participants modify contribution elections?

[ ] At any time provided by IRSregulations[ ] Pursuant to Plan Administrator procedures

**3.** May participants revoke election due to reduction hours of service? [ ] Yes [ ] No

**4.** May participants revoke election due to enrollment in a QHP offered through a marketplace? [ ] Yes [ ] No

**5.** May participants continue pre-tax coverage non-FMLA leave? [ ] No[ ] Yes, for Enter specific benefits, if applicable

**6.** May participants continue to be reimbursed on FMLA leave for Dependent Care through the end of the Plan Year or grace period after ceasing coverage? [ ] No[ ] Yes, effective Month Day, Year

**F. Plan Operations:**

**1.** Active participant Deadline for filing claims [ ] None [ ]  # of days days after end of Plan Year

[ ] By Description

**2.** Terminated Active participant Deadline for filing claims [ ] None [ ]  # of days days after end of Plan Year

[ ] By Description

**3.** 2½ Grace Period following end of Plan Year for filing claims?[ ] No [ ] Yes(complete a & b)

 **a.** Effective date of Grace Period (if different than Original or Restated)” Month Day, Year

 **a.** Limited to accounts Describe accounts

**5.** Carryover of unused FSA balance? [ ] No [ ] Yes , up to $ Amount (not greater than $500) and effective Month Day, Year

**4.** Debit, credit or stored-value cards provided? [ ] Yes[ ] No

**5.** Permit Qualified Reservist Distributions (HEART Act)? [ ] Yes[ ] No

**6.** Plan Administrator is [ ] Plan Sponsor[ ] Committee [ ] Other Name of Plan Administrator

**7.** Indemnification of Plan Administrator [ ] None [ ] Standard [ ] Custom Describe type of indemnification

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8.** Method of employee identification [ ] SSN[ ] Employee ID [ ] None

**9.** Claims submitted to [ ] Plan Sponsor [ ] Other\* Name of claims administratior

**10.** Healthcare Reimbursement Account or Premium Conversion subject to COBRA? [ ] Yes[ ] No

 **a.** Number of days for participant to notify Plan Administrator of Qualifying event (not less than 60) # days

 **b.** COBRA notice contact person (if not Plan Sponsor)\* Name of administrator

**11.** Plan subject to HIPAA privacy rules? [ ] Yes[ ] No

**12.** Plan subject to FLMA? [ ] Yes[ ] No

**13.** Include HIPAA portability language in SPD? [ ] Yes[ ] No

\* Please attached name address and phone number

**14.** Minimum contribution for (leave blank if none)

 **a.** [ ]  Health Care Reimbursement Account Amount of description

 **b.** [ ]  Health Savings Account Amount of description

 **a.** [ ]  Dependent Care Reimbursement Account Amount of description

**15.** Attach list of Names and EIN’s of other employers adopting this plan, if applicable