**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?

NoYes, as of the Effective DateYes, 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 ismaximum 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 BenefitLimited Scope Other: Description

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

**f.** Expenses may be reimbursed for Participant Participant, Spouse & dependentspersons 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 NoneCompany’s sole discretion 2% of Compensation Other:  Description

**j.** Cash in lieu of benefits available?Yes NoYes, with limitation Describe limitiation

**E. Elections:**

**1. C**ontinuing Participants may make an election Pursuant toPlan Administrator ProceduresPrior 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 participateContinue same election Continue same POP election

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

At any time provided by IRSregulationsPursuant 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? NoYes, 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? NoYes, 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? YesNo

**5.** Permit Qualified Reservist Distributions (HEART Act)? YesNo

**6.** Plan Administrator is Plan SponsorCommittee Other Name of Plan Administrator

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

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

**8.** Method of employee identification SSNEmployee ID None

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

**10.** Healthcare Reimbursement Account or Premium Conversion subject to COBRA? YesNo

**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? YesNo

**12.** Plan subject to FLMA? YesNo

**13.** Include HIPAA portability language in SPD? YesNo

\* 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