**Premium Only Plan 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:**

**14.**  [Salutation] [Name] [Title]

[Phone AC] [Phone number] [Fax AC] [Fax number]

[Email]

**B. General Plan Information:**

**1.** Plan name: [Plan name]

**2a.** Original effective date of Plan: Click here to enter a date.

**3b.** Restatement of a previous plan? Yes  No

**2c.** If "Yes", effective date: Click here to enter a date.

**3a.** Plan Year End: [Month Day]

**3b.** The Plan has a short plan year: Yes No

**3c.** If “Yes", start date Click here to enter a date. **4d.** end date Click here to enter a date.

**C. Eligibility:**

**1.** In addition to eligibility requirements under the applicable insurance contracts, employees must meet the following:

**1a**. Minimum age? YesNo Minimum age if “Yes” [ ]

**1b.** Service requirements:

None

**[**# of hours] hours of service

**[**# of days]days of service

**[**# of months]months of service

**[**# of years]years of service

**2.** Entry date:

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

**3.** Other revisions to age and service rules: [Describe]

No  Yes, as of [Month Day, Year]

**4.** Ineligible employees:

Employees covered under a collective bargaining agreement

Leased employees

Nonresident aliens

Part time employees working less than [# hours]per week

Other [Describe]

**5.** Other revisions to Eligible Employee: [Describe]

**D. Leave and Re-employment**

**1.** FMLA Leave of Absence (skip if FMLA does not apply)

For a paid FMLA leave, Participant may

**1a.** Cease contributions? Yes No

**If the answer to 1a is “Yes”;**

**1b.** Pre-pay prior to leave? Yes No

**1c.** Continue payments if not on COBRA? Yes No

**1d.** Repay employer on return from leave? Yes No

**1e. E**mployer may recover suspended contributions upon return? Yes No

**1f.** Participant may continue coverage on unpaid leave? Yes No

**2.** Termination of participation for an employee who becomes ineligible will occur on:

Date of termination of employment

Last day of payroll period

Last day of the month

Last day of Plan Year

Other [Describe]

**3.** Re-employment

**3a.** within 30 days:  Automatically reinstate  Resume next plan year

**3b.** after 30 days:  Automatically reinstate at termination  Resume next plan year  Employee election

**4.** Participants may revoke coverage for a family covered under a Marketplace QHP? Yes No

**E. Coverage & Contributions**

**1.** Employer group health

Employer dental

Employer vision

Employer short-term disability

Employer long-term disability

Employer accidental death & dismemberment

COBRA continuation (group health)

Premiums for other coverage:

[Other coverage 1]

[Other coverage 2]

[Other coverage 3]

[Other coverage 4]

[Other coverage 5]

**2.** Provide automatic enrollment? Yes No

**3.** Prior year elections will automatically apply? Yes No

**4.** Participants may adjust elections:

Pursuant to Plan Administrator procedures;

At any time permitted under IRS regs:

Other [Describe]

**F. Administrative**

**1.** Method of employee identification: SSNEmployee ID None

**2.** Plan Administrator address Same as Plan Sponsor Other [Name & address]

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

**4.** State of laws governing Plan: