**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? [ ] Yes[ ] No 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 [x] 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: [ ] SSN[ ] Employee 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: