



Section 125/FSA Set Up Form

Full legal name of the Employer: _____

Effective Date: _____

Plan Year: _____ Begins (mm/dd): _____ Ends (mm/dd): _____

Is first year a short Plan Year? Yes / No

If yes, please provide: Start Date: _____ End Date: _____

Plan Number: 501 502 503 504 505 506
(if none selected, one will be assigned)

Pay Periods

Weekly Bi Weekly Semi Monthly Monthly

Plan Start Date	Plan End Date	First Payroll Date	Last Payroll Date	# of Payrolls per plan Year

Funding Options

_____ Mail contributions to ASI each applicable Pay Period.

_____ Complete an ACH authorization to allow ASI to electronically transfer funds from your account per applicable pay period.

A contribution report must be submitted to ASI each pay period

Debit Card (Unreimbursed Medical Only)

_____ Yes (Note - 10% deposit required, 10-15 business days for delivery)

_____ No

Plan Eligibility

The same day employee becomes eligible for Group Medical Plan.

The first regularly scheduled working day on which the employee first performs an hour of service for the employer for compensation.

Other: _____

Please indicate if any of the following employee classifications are going to be excluded from enrolling in the plan:

There are no exclusions; or

The following classes of employees are excluded (check all that apply):

Leased employees

Contract workers and independent contractors

Temporary employees and casual employees

Individual paid by a temporary or other employment-staffing agency

Employees covered under a collective bargaining agreement (Union)

Other (specify): _____

Eligibility Requirements

Employee has been employed by the Employer for _____ consecutive calendar days and is regularly scheduled to work _____ hours or more per week; or

Other (Specify): _____

Employees who first become eligible to participate in the plan mid-year may commence participation on:

The first day of the month after eligibility requirement has been satisfied

The first day of the following plan year

Employees who are terminated for any reason and are rehired within 30 days will be subject to eligibility requirements as a new hire: Yes / No

Employees who cease to be eligible for reasons other than termination such as reduction in hours or disability leave of absence and are reinstated to eligible status outside of 30 days:

Must complete the stated waiting period in order to become eligible

Do not need to complete the waiting period before becoming eligible

Plan Benefits

The employer is offering the following benefits under this plan (check all that apply):

- Premium Only Plan Medical FSA Benefits Dependent Care Benefits
- Limited FSA Benefits (HSA Compatible)

Please indicate which Premium Only Plan Benefits will be offered pretax (check all that apply):

- Medical Insurance Dental Insurance Vision Insurance
- Group Term Life Insurance AD & D Insurance Disability Insurance
- Cancer Insurance Hospital Indemnity HSA Contributions*
- Prescription Drug Coverage Other: (Specify) _____

**If offering an HSA program, medical FSA expenses will be limited for those participating in the HSA to qualified dental, vision and OTC expenses.*

Employees who choose not to participate in the Health Insurance Plan (not available with Flex Benefits):

- Will not be entitled to receive cash in lieu of coverage
- Will be entitled to receive cash in lieu of such coverage in the amount of: _____

Medical FSA Component

The **maximum** annual benefit amount that a participant may elect to receive for medical care expenses incurred in any plan year shall be: _____

Coverage for a participant who enters the medical FSA component mid-year:

- Will be allowed to elect the entire maximum annual benefit amount; or
- Will be allowed to elect a prorated benefit amount based on the total months remaining in the plan year.

A participant who has elected to receive Medical FSA benefits for a plan year, may request reimbursement from the administrator no later than:

_____ 60 or _____ 90 days following the earlier of (a) the close of the plan year in which the expense was incurred or (b) the date of the employee’s termination.

Would you like to allow a grace period of 2 ½ months for the medical component?

- Yes No

Dependent Care Component

The **maximum** annual benefit amount that a participant may elect to receive for dependent care expenses incurred in any plan year shall be \$2500 if the employee is married but filing separately and \$5000 if the employee is married and filing a joint return or is a single parent.

A participant who has elected to receive Dependent Care benefits for a plan year, may request reimbursement from the administrator no later than:

____ 60 or ____ 90 days following the earlier of (a) the close of the plan year in which the expense was incurred or (b) the date of the employees termination.

Would you like to allow a grace period of 2 ½ months for the medical component?

____ Yes ____ No

Administrative Fees

- One Time Set up fee **\$300** Document Preparation POP/**\$300**
- Monthly PEPM Fee **\$6.00** *Includes the option of a debit card, and requires a 10% deposit subject to a \$35.00 minimum monthly*
- Annually Billed Fee **\$250.00**

Related Employers That Have Adopted This Plan:

(a) The employer signing this agreement (check one only): ___ is ___ is not affiliated with any employer that under Code d 414(b), (c), or (n), is treated as a single employer.

(b) If the employer is so affiliated, the full legal names of the Related Employers, their Employer Identification Number (EIN) and whether or not the Related Employers have adopted this plan are listed below:

Full Legal Name: _____ EIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Full Legal Name: _____ EIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Full Legal Name: _____ EIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Full Legal Name: _____ EIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Certification of Accuracy

I, _____ certify that the information provided on this worksheet is accurate to the best of my knowledge. I understand that ASI will utilize this information for preparation of our Plan Document and Summary Plan Document.

Signed _____ Date _____