



Section 125 Premium Only Set Up

Full legal name of the Employer: _____

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)

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

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: _____

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: _____

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 _____