Section 125 Premium Only Plan

Set-up Form

Full legal name of the Employer:____

Effective Date: _____________

Is the Employer a member of one of the following groups?

☐ Affiliated Service Group ☐ Controlled Group

If yes, please list all members of the group:

____

Plan Number: ◻ 501 ◻ 502 ◻ 503 ◻ 504 ◻ 505 ◻ 506

(if none selected, one will be assigned)

Plan Benefits

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

____Medical Insurance ___ Dental Insurance __ Vision Insurance

___Disability Insurance ___ Group Term Life Insurance ____HSA Contributions

__ Other: (Specify)_________________________

Is your company subject to FMLA?

___ No (1-49 employees) ___ Yes (50+ employees)

Provide for automatic employee enrollment under the Plan? ☐ Yes ☐No

Plan permits participants to elect cash in lieu of coverage? ☐ Yes ☐No

If yes, please provide the maximum amount of cash the participant is able to receive: $______

Are there related employers that will be adopting this Plan? ☐ Yes ☐No

If yes, please list full legal name for all employers adopting this Plan:

Full Legal Name:____

Full Legal Name:____

Full Legal Name:____

Full Legal Name:____

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 Description.

Signed____Date____________