



David K. Young, Consulting

Certified Employee Benefit Specialist

11107 WURZBACH, SUITE 403
SAN ANTONIO, TEXAS 78230
(210) 558-0999 / (210) 641-7771 FAX
dyoung@connecti.com

GROUP INFORMATION FORM

Plan Type: ' Flexible Spending Accounts (FSA) ' Premium Only Plan (POP)

If you currently have a Section 125, please number the participants in the FSAs____ POP____

Following is the format that I use when completing an adoption agreement/SPD for a Section 125. When gathering the information for a plan, please complete all the blanks following:

A. Employer Information

1. Name of Employer: _____
2. Address: _____ (street address, city, state, zip)
3. Telephone: _____
4. Employer Tax Identification Number: _____
5. Nature of Business (if known list SIC): _____

Organization Type: ' Corporation ' Sub-chapter AS@ ' Professional Corporation ' Professional Association ' Partnership ' Sole Proprietorship ' Government Agency ' Other (define) _____

6. Name of Plan: _____
7. Plan Number: _____
8. Plan Administrator, if other than Employer: _____
9. Plan's contact person, address, and telephone number: _____

B. Effective Date

Effective Date of Plan: _____

If this is an amendment to an existing plan,

(1) Effective Date of the Restatement and Amendment: _____

(2) Original Effective Date of Plan: _____

C. Plan Year

The first plan year began on _____ and ended _____

Subsequent Plan Years are from _____

D. Eligibility Requirements for Participation

1. Length of Service: _____.

the Group Hospital and Surgery Insurance will be as set forth in the insurance policy. (See Section 4.4 of the Plan Document)

_____ 2. Disability and/or Accident Income Insurance - The terms, conditions and limitations for the Disability and/or Accident Income Insurance will be as set forth in the policy. (See Section 4.7 of the Plan Document.)

_____ 3. Dental Insurance - The terms, conditions and limitations for the Dental Insurance will be as set forth in the Insurance policy. (See Section 4.5 of the Plan Document)

_____ 4. Group Life Insurance - Limited to \$50,000 face amount per participant.

_____ 5. Vision Insurance - The terms, conditions and limitations for the Vision Insurance will be set forth in the Insurance policy. (See Section 4.8 of the Plan Document)

_____ 6. Cancer Insurance - The terms, conditions and limitations for the Cancer Insurance will be set forth in the Insurance policy. (See Section 4.9 of the Plan Document)

_____ 7. Health Care Reimbursement - (See Section 6.1 of the Plan Document)

_____ 8. Dependent Care Reimbursement - (See Sections 7.1 of the Plan Document)

Please state the number of days after **the end of the plan year** a participant will have to make a claim to prevent forfeiture of their account balance (normally 90 days is allowed)_____.

G. Change of Benefit Elections (See Section 5.4 of the Plan Document)

Any Participant desiring to make a change of election(s) must notify and make such election(s) within _____ days of an eligible event. For details outlining what events are considered examples of a change daily status and the procedures to make such election changes, see Section 5.4 of the Plan Document.

Please list all employees who meet the definition of Highly Compensated Employee or Key Employee.

1. Key employees for the 25 percent concentration test for flexible benefit plans, who, for the current or four preceding plan years, are: (circle all that apply below)

- a) An officer of the company receiving more than \$65,000 annual compensation
- b) Among the top 10 employees list **the one** employee who receives more than \$30,000 annual compensation and owning the largest interest in the employer.
- c) A more than 5 percent owner of the company.
- d) A more than 1 percent owner receiving more than \$150,000 annual compensation.

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

2) Highly compensated employees for current or preceding plan year:

- a) An officer of the employer;
- b) A 5 percent owner;
- c) Receiving an earned income exceeding \$80,000 in annual compensation;
- d) A spouse or dependent of any of the above.

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

Name: _____ a b c d Soc. Sec. Number: _____

Please attach all of the following if applicable:

1. The current Plan Document, Summary Plan Description, Trust Agreements, and Adoption Agreement;
2. Up to three of the previous plan year's IRS Form 5500s;
3. Current employee census;
4. Previous discrimination tests;
5. Any correspondence received from the IRS or DOL;
6. Signed David K. Young Service Agreement to administer the Plan;
7. First month's administration fee and/or setup fee.

Name of the person providing the above information and job title:

Name (please print)

Title

Telephone number and fax number

Date