



PREMIUM CONVERSION PLAN
Plan Document Checklist

ABPM REP:

1. NAME OF EMPLOYER
(Exactly as it is to appear with punctuation)

2. EMPLOYER'S ADDRESS
(Physical)
(PO Box)
(City) (State) (Zip)

Telephone
Fax #

3. CONTACT PERSONNEL
Human Resources:
HR Phone:
HR E-Mail Address
Payroll Department:
PR Phone:
PR E-Mail Address
Person Authorized to amend Plan:
(Name) (Title)

4. EMPLOYER'S TAX ID NUMBER

5. PLAN NUMBER
501 504
502 505
503 506

6. PLAN INFORMATION
New Plan
Amendment and restatement

7. PLAN YEAR
Begins (Month / Day) (January 1)
Ends (Month / Day) (December 31)
Is first year a short Plan Year?
Yes, beginning (Month / Day) (May 1)
N/A

8. EFFECTIVE DATE(S)
Initial effective date (Month / Day / Year) (1/1/2024)
This restatement (Month / Day / Year) (1/1/2024)

9. EMPLOYER ENTITY
Corporation
S Corporation (2% shareholders not eligible)
Governmental Entity or Church
Limited Liability Corporation
Non-Profit Organization
Partnership (self-employed partners not eligible)
Sole Proprietorship (self-employed not eligible)

10. ELIGIBLE CLASS OF EMPLOYEES
All Employees who satisfy eligibility requirements
Salaried Employees only
Hourly Employees only
All Employees EXCEPT:
Commissioned Employees
Union Employees
Leased Employees
Part-time Employees, expected to work less than
hours per week
Non-Resident Aliens
Employees not eligible under the Employer's Group
Medical Plan
Other exclusion

11. CONDITIONS FOR ELIGIBILITY
Same as Employer's group medical plan
For first Plan Year only, anyone employed on the effective
date of the Plan is eligible, thereafter: (Choose one from a-d below)
For all years, eligibility is as follows: (Choose 1 below)
a Date of hire (No service required)
b. days after date of hire
c. months after date of hire
d. years after date of hire

12. ENTRY DATE
First day of pay period following date requirements were met
(See #11)
First day of month following date requirements were met as
indicated in #11
Date conditions for eligibility are met (See #11)
First day of Plan Year following date requirements were met
as indicated in #11
Same as Employer's Group Medical Plan

13. FAMILY AND MEDICAL LEAVE ACT. Is the Employer
subject to these provisions?
Yes
No

14. **CONTRIBUTIONS. Plan will provide for**
Salary reduction contributions ONLY (No Employer contribution)
Employer contributions ONLY (No salary reductions)
Both salary reductions AND Employer contributions

15. **EMPLOYER CONTRIBUTIONS**
For each Plan Year, Employer will contribute

N/A
_____ % of compensation per participant
\$ _____ per participant
Discretionary
Other

AND the contributions shall be made

At the beginning of Plan Year
Pro rata each pay period

AND the contributions are convertible to cash?

Yes
No

AND the contributions made to:

Health Savings Account (Q. 19.)
Employee Premiums

16. **PREMIUM PAYMENTS may be elected for**

Health insurance
Dependent health insurance ONLY

PREMIUM PAYMENTS may be elected for

Group Term Life Insurance
Disability Insurance
Dental Insurance
Cancer Insurance
Vision Insurance
Accidental Death and Dismemberment Insurance
Other

17. **HEALTH PREMIUM PAYMENTS. Are the premium payments elected above self-insured by the Employer?**

Yes Provider: _____
No

18. **GROUP HEALTH PLAN CHANGE IN STATUS: Election revocation allowed for the following changes?**

Reduction in hours of service.
Marketplace/Exchange participation.

19. **IS A HEALTH SAVINGS ACCOUNT (HSA) PROVIDED BY THE EMPLOYER?**

Yes
No

20. **BENEFIT ELECTION PERIOD SHALL BE**

The _____ day period prior to each Plan Year.
Established by administrator in a nondiscriminatory manner.

21. **IS AUTOMATIC ENROLLMENT for insured benefits provided under this plan?**

Yes
No

22. **PARTICIPANTS WHO FAIL TO SIGN A NEW ELECTION FORM SHALL**

Be considered to have elected not to participate for upcoming Plan Year.
Continue same elections as prior year.

23. **WILL MORE THAN ONE COMPANY BE COVERED UNDER THIS PLAN?**

No or N/A
Yes, include signature lines for:

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)

24. **ARE THERE SEPARATE DIVISIONS WITHIN THIS COMPANY?**

No or N/A
Yes, include signature lines for:

(Company Name)

(Street Address)

(City) (State) (Zip)

(Tax ID Number)
(NOTE: Please attach additional affiliated Employer information)

25. **FEES**

Initial Set-Up Fee \$ _____
Annual Re-Enrollment Fee \$ _____

26. **BROKER NAME & ADDRESS**

(Name)

(Company)

(Address)

(City) (State) (Zip)

E-mail Address _____

Telephone: _____

Fax: _____

Federal Tax ID# _____

[If Broker/Agent wants to be primary point of contact, please enter agent's name and email in the Human Resources section on #3.](#)

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Prepared By: _____

(Revised September 2024)

1. Total number of Employees: _____

2. Total number of Employees eligible to participate: _____

3. Highly Compensated Employees:

4. Key Employees:

DEFINITIONS:

HIGHLY COMPENSATED EMPLOYEE (HCE):

- An officer; or
- A shareholder owning more than 5% of the voting power or value of all classes of stock of the Employer; or
- Highly compensated based on compensation level, to mean an Employee who earns in excess of \$120,000 in the prior Plan Year or, if elected by the Employer, who was in the 20% top-paid group; or
- A spouse or dependent of an individual described above.

KEY EMPLOYEE:

- An officer of the Employer with annual compensation greater than \$175,000 (as indexed for cost-of-living adjustments); or
- A more-than-5% owner of the Employer; or
- A more-than-1% owner of the Employer with annual compensation in excess of \$150,000 (not indexed).



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