PREMIUM CONVERSION PLAN

ABPM REP:

Plan Document Checklist

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) (1/1/2018)

This restatement _____
(Month / Day / Year) (1/1/2018)

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. 24.)
☐ 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

	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# _____

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Prepared By: _____

(Revised December 2017)

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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