



Flexible Spending Account Plan Application

1. Legal Name of Company Sponsoring Plan: _____
2. Business Entity Type:
 - C Corp.
 - Sole Proprietorship
 - Partnership
 - Not-for-Profit
 - Government Entity or church
 - S Corp.
 - Limited Liability Company
3. Principal Business Activity: _____
4. Federal Employer Identification Number (Must be 9 digits): ____ - _____
5. Contact Person: _____
Title: _____
6. Street Address (No PO Boxes): _____
City, State, Zip: _____
7. Phone Number: _____ Fax Number: _____
E-mail: _____
8. Effective Date – This FSA plan will be:
 - () A new plan effective as of (date) _____
 - () An amendment and restatement is effective as of (date) _____
 - (1) This amendment and restatement is effective as of (date) _____
 - (2) State the effective date of the original plan (date) _____
 - (3) State the plan number (consult your last Form 5500 for this number assigned to your plan) _____
9. Plan Year – The first plan year for the FSA will be:
 - A 12-consecutive-month period beginning (date) _____ and ending (date) _____
 - A short plan year beginning (date) _____ and ending (date) _____
10. Employer’s Principal Office – This FSA plan shall be governed under the laws of the:
 - State of _____
 - Commonwealth of _____
11. All employees are eligible for the FSA Plan:
 - Employees not eligible under Employers group medical plan
 - Part-time Employees expected to work less than _____ hours per week
 - Commissioned Employees
 - Union Employees
 - Other (type & attach)
12. All employees can enter the FSA Plan:
 - Same as Employer’s group medical plan
 - _____ days after date of hire
13. Benefits – The benefits selected below shall be included in the FSA Plan:
 - Medical expenses not covered by insurance and
 - Annual maximum per participant shall be \$ _____
(typically limits are between \$1,500 and \$2,600 annually)

- Adult and child daycare expenses
 - Health and other insurance (select coverages below):

Health Insurance Premiums	Disability Insurance**
Critical Illness Insurance	Dental Insurance
Vision Care Insurance	Accidental Death/Dismemberment
Group Term Life Insurance*	Cancer Insurance
Other Insurance (specify)	
 - Individual Health and Disability Insurance

14. Contributions – The contributions for the FSA Plan will be:

- Employee (salary reduction) contributions only
- Employer contributions only
- Both salary redirection and Employer contributions

\$ _____ annually per Participant \$ _____ Employer contributions convertible to cash

15. Legal names(s) of affiliated company(ies) that will be covered by this plan:

(provide names, tax ID numbers and full addresses on attachment)

16. Total number of employees: _____

17. Pay cycles – Payroll is provided (weekly, semi-monthly, monthly, etc.)

Deductions to begin: _____

18. Reimbursement account checks should be:

- Sent to the group administrator once a week to be distributed
- Sent to the group administrator daily to be distributed
- Sent directly to the employee
- Electronically transferred to the employee's bank account

19. Is your group currently:

- Self Funded
- Fully Insured

20. Plan Administrator Signature: _____

*This should be the employer or his designee. The Benefit Group will provide administrative services but will not be the Plan Administrator.

Date: _____

Additional Notes:

If Individual Health and Disability Insurance marked – send advice letter.