AMERICAN BENEFITS GROUP

# PREMIUM ONLY PLAN (POP) COMPLIANCE SOLUTION
# CLIENT INFORMATION FORM

## Includes Plan Document, yearly restatements of the Plan Document (as needed) and annual Nondiscrimination Testing

**The POP Documents will be created and sent to you once payment has been received and cleared, the POP Annual Compliance Subscription Cost is $395.**

## Company Profile

Name of Plan Sponsor (Company): _____

Mailing Address: _____City: _____State: ____ Zip: _____

Executive Officer: _____ Title: _____

Telephone: _____ Email Address: _____

Type of Organization: Select Under Laws of (State): _____

Employer Fed Tax ID#: _____ Date of Incorporation: _____

Employers *(if any):* _____ _____ _____

**Who will be the Administrator of this Plan?** _____

Title: _____ Telephone: _____

Fax: _____ Email Address: _____

Do employees of an entity with a different EIN than the employer's EIN participate in this Plan? ☐ Yes ☐ No

If yes, please complete the Affiliates Questionnaire linked here download affiliates questionnaire

## POP Plan Details

Original Plan Effective Date: _____ Effective Date of Amendment: _____

Start Date for this Plan Year: _____ End Date: _____

Participation in the Plan Begins (*please check*):

- ☐ As of date of hire
- ☐ From date of hire: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other _____
- ☐ First of the month following: ☐ DOH ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other _____
- ☐ Other *(please explain)*: _____

Minimum Hours per Week required for benefit eligibility: _____

Short Plan Year?

Renewal Year Start (only if short plan year): _____ Renewal Year End (only if short plan year): _____

Please check the benefits to be included under your Section 125 Cafeteria Plan:
You may not permit pre-tax payroll deductions unless the benefit is included in you POP)

- ☐ Group Medical Insurance
- ☐ Group Dental Insurance
- ☐ Group Vision Insurance
- ☐ Health Savings Accounts (HSA)
- ☐ Group Term Life Cancer
- ☐ Cash In Lieu of Benefits
- ☐ Long-Term Disability Insurance
- ☐ Short-Term Disability Insurance
- ☐ Accidental Death and Dismemberment Insurance
- ☐ Critical Illness Insurance
- ☐ Hospital Indemnity Insurance
- ☐ Intensive Care Insurance
- ☐ Special Health Event _____
- ☐ Other _____ _____

Employer intends this Plan to qualify as a "Simple Cafeteria Plan" for purposes of Code Section 125(j): Yes ☐ No ☐

What is a Simple Cafeteria Plan?

Employer uses "Top-Paid Group" Election for 401(k) Nondiscrimination Testing purposes: Yes ☐ No ☐

Please return this completed form to: implemenation@amben.com

Contact: _____ Title: _____

Authorized Signature: _____ Date: _____

**American Benefits Group and its employees are not engaged in the practice of law and do not provide legal advice or consultation.**