PREMIUM ONLY PLAN (POP)
With H.S.A Features
PLAN SET-UP

COMPANY INFORMATION	Referring Agent Name:	Agent's Company:
Employer Legal Name:		Contact Person:
Address:		Phone:
City: State: Zip:		Email Address:
List Any Affiliated Companies:		
EIN: ☐☐-☐☐☐☐☐☐☐		Number of Employees on Group Med Insurance: ☐☐,☐☐☐
☐ C-Corporation ***Owners may participate, but are limited to 25 % of total plan usage**		☐ Sole Proprietor ☐ Partnership ☐ Sub-S ☐ Other_____ ☐ LLC (taxed as Corp) ☐ LLC (taxed as Partnership) ***2% or more owners of any of the above groups <u>may not</u> participate**

PLAN PROVISIONS

This New Plan will become Effective: ☐☐-☐☐-☐☐☐☐	If This Is A Take-Over Of An Existing Plan, What was the Original Effective Date of the Existing Plan? ☐☐-☐☐-☐☐☐☐	Take-Over Date Of the Existing Plan: ☐☐-☐☐-☐☐☐☐

Our 12 Month Plan Year Begins:
☐Jan 1 ☐Feb 1 ☐Mar 1 ☐Apr 1 ☐May 1 ☐June 1 ☐Jul 1 ☐Aug 1 ☐Sep 1 ☐Oct 1 ☐Nov 1 ☐Dec 1

Is this a short Plan Year? ☐ Yes ☐ No → **IF YES**, Plan Year Begins: _____ Plan Year Ends: _____

Exclude Part-time? ☐ Yes ☐ No → Part-Time defined as working less than : ☐☐ Hours per Week

Eligibility: 1st of Month Following: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ _____Days of Employment
OR ☐ First of the Month following Date of Hire
OR ☐ The same day you are eligible for the Group Health Insurance

Fiscal Year End: ☐☐/☐☐	Types of Insurance Offered: ☐ Medical ☐ Dental ☐ Vision ☐ Life Insurance (up to $50K)

COMPANY AUTHORIZATION

I understand that Ben-X, LLC will prepare the Plan Document, Summary Plan Description and appropriate tax forms at my direction. This will allow the Company to purchase certain insurance benefits on behalf of the Employees on a tax advantaged basis.

Sign Here _____ Company Representative _____ Title _____ Date

☐ ACCEPT Checking the Accept box will serve as your electronic signature.

Ben-X, LLC · Website: www.Ben-X.com · Fax (801) 224-1903 · Toll Free (888) 433-2369 · Email: Support@BenXco.com

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