



TRANSIT/PARKING 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: <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Number of Employees on Group Med Insurance: <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	
<input type="checkbox"/> C-Corporation *Owners may participate, but may be limited		<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Sub-S <input type="checkbox"/> Other _____ <input type="checkbox"/> LLC (taxed as Corp) <input type="checkbox"/> 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: <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		If This Is A Take-Over Of An Existing Plan, What was the Original Effective Date of the Existing Plan? <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		Take-Over Date Of the Existing Plan: <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Our 12 Month Plan Year Begins: <input type="checkbox"/> Jan 1 <input type="checkbox"/> Feb 1 <input type="checkbox"/> Mar 1 <input type="checkbox"/> Apr 1 <input type="checkbox"/> May 1 <input type="checkbox"/> June 1 <input type="checkbox"/> Jul 1 <input type="checkbox"/> Aug 1 <input type="checkbox"/> Sep 1 <input type="checkbox"/> Oct 1 <input type="checkbox"/> Nov 1 <input type="checkbox"/> Dec 1		Is this a short Plan Year? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES , Plan Year Begins: _____ Plan Year Ends: _____	
Exclude Part-time? <input type="checkbox"/> Yes <input type="checkbox"/> No → Part-Time defined as working less than :		<input type="text"/> <input type="text"/> Hours per Week	Fiscal Yr. End _____
Eligibility Following: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> _____ Days of Employment <input type="checkbox"/> DOH			
Maximum Transit/Parking Limit: <input type="checkbox"/> Max allowed by IRS or the lesser amount of: <input type="checkbox"/> \$ _____		Run Out Period Following the Plan Year: <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	
Company Contribution Amount : <input type="checkbox"/> Yes, we would like to contribute \$ _____ monthly <input type="checkbox"/> No, we do not want to contribute funds monthly			
CLAIM PAYMENT			
Company Pay Cycle: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi- Monthly <input type="checkbox"/> Monthly			
***** First Pay Date of the plan year ____/____/____		***** Annual Debit Card fee(s) charged to: <input type="checkbox"/> Client <input type="checkbox"/> Participant <small>*See Company Authorization below for additional details</small>	
Contribution Transfer Method: <input type="checkbox"/> Wire Transfer <input type="checkbox"/> Mail Check <input type="checkbox"/> Pay Cycle Draw (Attach ACH Authorization Form)			
COMPANY AUTHORIZATION			
I understand that Ben-X, LLC processes claims each business day. Payment will only be made from funds on deposit. Timely transfer of funds each pay cycle will allow prompt claim payment. Additional transfers to cover excess claims may be requested. An initial prefund deposit of 5% of the total annual elections is required.			

Company Representative		Title	Date
<input type="checkbox"/> 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			