PLAN SET-UP FORM
LIMITED PURPOSE FSA
Dental/Vision & Dependent Care Only

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 may be limited**

☐ Sole Proprietor ☐ Partnership ☐ Sub-S ☐ Other _____
☐ LLC (taxed as Corp) ☐ LLC (taxed as Partnership)
***2% or more owners of any of the above groups may not 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: ☐☐-☐☐-☐☐☐☐

Plan Year Begins: ☐ Jan 1 ☐ _____ Plan Year Ends: ☐ Dec 31 ☐ _____

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

Fiscal Yr. end:_____

Eligibility Following: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ _____Days of Employment ☐ DOH

Maximum Annual Election: ☐ Max allowed by IRS
or the lesser amount of: ☐ $_____

Dependent Care: ☐ $5,000 IRS Max ☐ Not offering

Run Out Period Following the Plan Year: ☐ 60 Days ☐ 90 Days

Allow Carry-Over Amount : ☐ $500 (Max allowed by IRS or the lesser amount of: ☐ $_____
☐ We do not elect to offer this option to carry over a specified amount of unused claim money.

CLAIM PAYMENT

Company Pay Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi- Monthly ☐ Monthly

****** First Pay Date of the plan year ____ /____/_____

****** Annual Debit Card fee(s) charged to: ☐Client ☐Participant
*See Company Authorization below for additional details

Contribution Transfer Method: ☐ Wire Transfer ☐ Mail Check ☐ 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.

Sign Here _____ Company Representative _____ Title _____ Date

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

Print Form Clear Form