




# PREMIUM ONLY PLAN (POP) PLAN SET-UP

<b>COMPANY INFORMATION</b>		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"/> <input type="text"/>		Number of Employees on Group Med Insurance: <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	
<input type="checkbox"/> C-Corporation <b>*Owners may participate, but are limited to 25 % of total plan usage</b>		<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) <b>*2% or more owners of any of the above groups <u>may not</u> participate</b>	
<b>PLAN PROVISIONS</b>			
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"/> <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"/> <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"/> <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   → <b>IF YES</b> , 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			
Eligibility: 1 <sup>st</sup> of Month Following: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> _____ Days of Employment OR <input type="checkbox"/> First of the Month following Date of Hire OR <input type="checkbox"/> The same day you are eligible for the Group Health Insurance			
Fiscal Year End: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Types of Insurance Offered: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life Insurance (up to \$50K)	
<b>COMPANY AUTHORIZATION</b>			
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 participants to pay for their portion of the Group Insurance on a pre-tax payroll deduction basis.			
		_____	
Company Representative		Title	Date
<input type="checkbox"/> ACCEPT   Checking the Accept box will serve as your electronic signature.			
Ben-X, LLC   • Website: <a href="http://www.Ben-X.com">www.Ben-X.com</a> • Fax (801) 224-1903   • Toll Free (888) 433-2369   • Email: <a href="mailto:Support@BenXco.com">Support@BenXco.com</a>			