

Checklist to Adopt Section 125 Flexible Spending Plan

The undersigned Employer, by executing this Adoption Agreement, elects to (establish/amend) the accompanying Flexible Benefits Plan by adopting said plan document in full. The Employer makes the following elections granted under the provisions of the plan.

1. The Name and Address of the Employer:

The Employer shall be the **Plan Sponsor** and **Plan Administrator**.

The telephone number: _____

2. Business Entity Type:

- C Corp.
- Sole Proprietorship
- Partnership
- Government Entity or church
- Not-For-Profit
- S Corp
- Limited Liability Company

3. Federal Employer Identification Number: _ _ _ - - _ _ _ _ _

4. The Contact Person shall be: _____

The e-mail address: _____

5. Effective Date: Plan Year:

- This new Section 125 Flexible Benefits Plan shall be effective as of _____.
 - If amended and restated, the Plan was originally effective on _____
- Future Plan Years will be based on a full 12-month period beginning each _____ and ending each _____.

6. Plan Number: _____ New Plans will be assigned 501

7. Eligible Employees:

All Employees shall be eligible to participate in the Plan, **except:**

- Under the Health Savings Account, individuals who fail to qualify as an Eligible Individual for a Health Savings Account under Code Section 223(c);
 - With the exception of the Health Savings Account program, any self-employed person(s), within the meaning of Code Section 401(c), including independent contractors, a greater than 2% shareholder in a Subchapter S corporation, a partner in a partnership, or any owner or member of a limited liability company that is treated like a partnership for tax purposes;
 - A relative, within the meaning of IRC Section 318, of one of the above self-employed person(s)
- AND:

- Employees not eligible under Employer group health insurance plan.
- Part-time Employees expected to work less than _____ hours per week.

Commission salespersons.

Any Employee of the Employer who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and one or more employers unless the collective bargaining agreement requires the employee to be included within the Plan.

Any Employee who is temporary or seasonal (working for the Employer less than 6 months of the year).

Any Leased Employee, as well as any independent contractor, or other "statutory employee" who is not treated as a common law employee of the Employer for payroll purposes, regardless of any other court or administrative agency determination.

Nonresident Aliens.

Other: _____.

8. Plan Entry Date:

Employees eligible to participate may become Participants:

Same as Employer's group health insurance plan.

_____ days after date of hire.

9. Benefits:

The following Benefit Options shall be included in the Plan:

Healthcare Flexible Spending Account subject to an annual limit of \$ _____.

Dependent Care Assistance Program subject to the maximums contained in Section 7.9 of the Plan Document.

Individual, Privately Held Health Insurance (Proof of Policy Coverage Required);

Insurance Benefits. The Employer's Group Health Insurance (including health insurance, dental and vision insurance, AD&D, etc.);

Group Term Life Insurance;

Disability Insurance;

Employee Health Savings Account Contributions, subject to the terms and conditions of Article X of the Plan Document;

10. Contributions:

The contributions for this Plan shall be:

Employee (Salary Redirection) contributions only;

Employer Contributions only, which shall be: \$ _____ annually per Participant of which \$ _____ that is convertible to cash compensation. A Participant will be credited on a _____ (pay period, annual) basis; or

Both Employee (Salary Redirection) and Employer Contributions. Employer Contributions which shall be: \$ _____ annually per Participant of which \$ _____ that is convertible to cash compensation. A Participant will be credited on a _____ (pay period, annual) basis.

11. Claims Extension Period

The Plan shall shall not be subject to the terms and conditions of Section 15.16 Claims Extension Period.

Does your plan offer Health Savings Accounts? yes no **If so, questions 12, 13 & 14 must be completed**

12. Does your plan offer a High Deductible Health Plan with a Health Savings Accounts?

yes no **If yes, answer the following questions**

1. Contributions:

Employer contributes to the plan? yes no **If yes, answer next line**

What is the employer contribution formula? Equal amounts or percentage

Please explain _____

How often are employer contributions made ? ie monthly, quarterly annually?

Please explain _____

Employee contributions ?

Do employees contribute to the HSA plan ? yes no **If yes, answer next line**

Are employee contributions pre-taxed ? yes no

13. Affiliated Employers:

The following Employers have adopted this Plan:

14. Authorized Signatures:

Date _____
Company Name

By _____
Authorized Signature

Date _____
Affiliated Employer

By _____
Authorized Signature

15. Discrimination Testing Information:

Stockholders:

_____ % _____ %
_____ % _____ %

Company Officers:

16. Total number of employees _____

17. Pay cycles

weekly (52 p.p.) bi-weekly (26 p.p) semi-monthly (24 p.p) monthly (12 p.p)

Deductions to begin _____

Payroll is prepared: ___ In house

___ Out sourced (specify payroll company): _____

18. Funding/Checking Account for Reimbursements

- Client Checking Account
- Davey Administration Trust Account
- Interested in the Debit Card option

Completed by _____ Date _____

Signature

Send completed form to:

Davey Administration Group
Employee Benefit Designs & Administration
3451 West Shaw Ave Suite 101
Fresno, CA 93711
(559) 436-6606
FAX 436-4850