SABC

"Your Flexible Benefit Cafeteria Plan Specialist"

Section I. Employer Information

NEW GROUP FORM Co #

THIS FORM IS A FILL IN THE BLANK FORM, JUST TAB BETWEEN FIELD ENTRIES, PRINT AND RETURN TO SABC.

(1) Employer (Legal) Name: *(List if a D.B.A. or any Subsidiaries)*

(2) Current Plan Year: *Begin Date:* *End Date:*

Change/Short Plan year Date: *(If Applicable)* *Begin Date:* *End Date:*

(3) Address:

Address:

City: State: Zip:

(4) Federal Tax Identification Number: - (5) Fiscal Year:

(6) Number of Locations? # *(Attach List)* (7) Total Number Of Full-Time Eligible Employees? #

(8) Has your Company ever had a Cafeteria Plan? ☐ Yes ☐ No (9) Initial effective Date of Plan?

(10) Form 5500 Filing Number: # *(If you Yes, to 8), Please Provide a copy of your last filed form)*

(Authorized Signer For The Cafeteria Plan)

(11) Appointed Plan Administrator Name: Title:

Email Address: Telephone #: ( ) Ext:

(12) Human Resource Contact/ Name: Title:

Email Address: Telephone #: ( ) Ext:

(13) Payroll Contact/ Name: Title:

(14) Email Address: Telephone #: ( ) Ext:

(Contact where all Reports will be Forwarded)

Section II. Employee Eligibility Period For Coverage

(15) Required Days Worked To Be Eligible: # Days (16) Required Hours Worked To Be Eligible: # Hours

(17) Employee Entry Period For Cafeteria Plan Will Be:

- ☐ 1st Day of the Month following THE date of eligibility
- ☐ The Date of Hire
- ☐ 1st Day of the Plan Year following Eligibility
- ☐ Other: _____

Please Note: You cannot have different entry dates for the Cafeteria plan based on employees Classification, therefore you must choose one:

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(18) Plan Style*: Employee Entry Option for Plan, * Open ☐ Closed ☐ Will your plan offer the presciption debt card?

** Open means employees may enter plan upon meeting eligibility, closed means entry is only at plan renewal.*

Section III. Employee Payroll Data

(19) Pay Modes: For Each Mode of Pay marked, Indicate the **First Pay Date** for the Plan year.

☐	Weekly Paid (52 times)	WEEKLY	(_____)
☐	Bi Weekly Paid (26 Times)	BI WEEKLY	(_____)
☐	Semi Monthly Paid (24 Times)	SEMI MONTHLY	(_____)
☐	Monthly Paid (12 times)	MONTHLY	(_____)

PLEASE NOTE IF DEDUCT ARE LESS THAN STANDARD

LIST FIRST PAY DATE: (By Pay Mode Date): _____

(20) Is your Payroll In House ☐ Out Sourced ☐

If Out Sourced, list Payroll Company Name:

Address:

City, State, Zip:

Telephone: ( ) Ext:

Contact Name:

(Please Authorize them to provide us with necessary information needed to set-up the Cafeteria Plan.)

Section IV: Employee Benefits Offered

(21) Indicate with an X What Benefits of the Cafeteria Plan you will offer:

Premium Only Plan ☐ **Flexible Spending:** Dependent Care ☐ Unreimbursed Medical Plan ☐

Premium Reimbursement Plan ☐ HRAs Plan ☐ HSAs Plan ☐ Insurance Sales ☐

(Please mark your choices)

Section V: Employee Benefits (Insurance Products Offered)

Insurance Benefit Type	Insurance Carrier/Provider	Mark X ONLY If you want this a mandated benefit	Deduction Mode of Benefit(s)
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

Section VI: Flexible Spending Accounts (Complete only if offering this Benefit)

For Unreimbursed Medical (URM):

(22) Unreimbursed Medical Expenses Plan Year Maximum is: $ _____

(Cannot exceed $10,000 for State of Mississippi Agencies/Schools Only)

(23) In the event a Participant, who participates in an Unreimbursed Medical Spending Account, terminates during the Plan Year, there are two options in which to choose for your plan. (Please Mark A or B)

Type A: COBRA TERM STYLE ☐

The Participant's Salary Reductions will terminate, as will the participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for **Unreimbursed** Medical Spending Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursements for any Unreimbursed Medical Spending Expense incurred during the Period of Coverage prior to termination, provided that the Participant (or the Participant's estate) claim is filed **with in the (60) day grace period, following the end of the plan year.**

Type B. FINAL PAY STYLE ☐

Employees participating in Unreimbursed Medical Spending Accounts participate for the full Plan Year, the Plan does not terminate when the employee terminates. Final reduction of the Participants Plan Year Annual election will be deducted from the Participant's final paycheck. The Participant ceases to be a Participant at the close of the Plan Year and is allowed the same grace period as a current employee.

(24) Would you like to offer the 2 ½ month extension, incurred period, for URM ONLY on your plan? ☐ Yes ☐ No

(This extension allows employees an additional incurred period after the Plan Year Closes, to incur expenses in the new Plan Year and be paid From the balances of the previous year). Your representative will discuss the option with you in detail.

Section VII. Flexible Spending Account Bank Set up (for office set up)

(25) Bank Name: _____ Location: _____

SABC can set up, monitor, and reconcile this clearing account for employer. Do you want this? _____

(26) Bank Routing Transit Number: | **(27) Bank Account Number:**

(28) Authorized Signer for Flexible Spending Account Reimbursements: _____

SABC Offers to sign for Company, This will allow us to mail checks directly to Individual. Do you want this? Y/ N

(29) Mail Check to: ☐ Individual ☐ Company ☐ Direct Deposit

Section VIII. HIPAA PRIVACY RULE REQUIREMENTS

With respect to disclosures of Protected Health Information (PHI) under the HIPAA PRIVACY RULE. the Employer acknowledges and agrees that the Service Provider (SABC) shall only disclose PHI in its possession to the following employees who are identified by the Employer as **(Designated Persons)** in accordance with 45 C.F.R. § 164.504(f), and that such disclosures are solely for purposes of carrying out plan administration functions that the Employer performs for its Group Health Plan and/or Health FSA Plan such as (1) Who is the appointed privacy officer?; (2) Who should employees contact to request a list of accounting of PHI disclosures?; (3) Who should employees contact to obtain a paper copy of their Summary Plan Description, or Privacy Notice; (4) Who should employees contact to file a complaint with the Plan over PHI violations; (5) Who should employees contact to request an amendment to PHI?; and (6) List personnel who will have PHI access for benefits administrations purposes only. Plan Administrator will be included in this list.

(30) Please complete PHI Eligible: *[List of **Designated Persons** by name or position]*

NAME/OR POSITION/OR CLASS OF EMPLOYEE:	*NAME/OR POSITION/OR CLASS OF EMPLOYEE:*

Privacy Officer: _____ *Title:* _____

SABC will only disclose information on PHI to this List of personnel provided for benefits administration purposes only.

Section IX. Non-Discrimination Testing

BUSINESS ENTITY TYPE: Required Information: *(EMPLOYERS MUST COMPLETE ALL PORTIONS)*

(31) Please mark the box for the type of business that applies. If you are unsure, please speak to your corporate secretary, as this information must be accurate.

- ☐ Subchapter S Corp
- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Limited Liability Corporation
- ☐ Limited Liability Partnership
- ☐ C Corp
- ☐ Government Entity or Church
- ☐ State Agency, School, County, County Hospital, Municipality
- ☐ Non-Profit

ALL PARTICIPANTS in a Section 125 plan must be "employees." "Employees" are defined by the regulations as to exclude self-employed Individuals. Partners, owners of a Sole proprietorship and shareholders in a Subchapter S Corporation who owns more than2% of the stock of the corporation. However, partnerships, sole proprietorships And Subchapter S Corporations are not prevented from sponsoring a Cafeteria Plan for the benefit of their common-law employees. (Example: If you are a 2% owner of a Subchapter S Corporation, cannot Participate). Based on the above, please list owners that would not be eligible:

(32) LIST OWNER(S) NAME:	SOCIAL SECURITY NO:

Section IX. Cont. Non Discrimination Testing (Key, Top Paid Group and Highly Compensated Employees)

Directions: Please list employees that apply, give name, social security number and indicate the number(s) of the category items Below that apply. List employees, shareholders and owners, as well as owner relatives that work for the company. Should you Need additional space, please attach a list.

Please base your answers on the preceding calendar year (prior year) income.

1. Officer(s) of the Company with greater than $150,000 *, as indexed, "Key Employees";
2. Employees with 5% Ownership of the Employer -* "Key Employees";
3. Employees with 1% Ownership of the Employer with income greater than $150,000 (not indexed) "Key Employees";
4. Employees who are a spouse or dependent (and relationship) of any individual falling into the above categories, "Key Employees";
5. Employee with 5% Shareholder stock or voting power (one any day of the year or the preceding year) * "Highly Compensated Employees and Key Employee"
6. An Officer of the Company "Highly Compensated Employee"
7. Employees with compensation of $105,000 or greater*, as indexed, "Highly Compensated Employees";

*Limits above are based on the IRS Indexed Contribution and Benefits Limits for qualified plans (IR 2004-122), as indexed.

List Employee Name:	Social Security No.:	Category # (Indicate category -1 thru 6 above that applies)

(If you need more space, please attach a separate list.)

Employees properly excluded under a plan's eligibility may nevertheless have to be counted for purposes of the Code's nondiscrimination tests. Excluding too many employees could cause the plan to fail one or more of these tests. Many nondiscrimination issues can be avoided through plan design. SABC performs Eligibility Test, in which IRS requires the plans eligibility be fair, consistent, and reasonable. Some employees may be excluded (on a uniform basis) because of their age, limited services, etc. SABC performs the Utilization test, (sometimes called the concentration or contributions and benefits tests) where comparable benefits are utilized by a fair number of employees at all compensation levels and in all positions. This test includes the Key Employee Concentration Test and the Owner's Test (To insure that Keys do not receive more than 25% of the total benefits under Code 125 plan) The Ownership and Key Test does not apply to collectively bargained plans, or officers or employees of governmental entities, but the highly compensated test does.

BY: _____ Date: _____

(Authorized Group Signer or Person Providing Information)

(Print Name of Signer: Name & Title): _____

BELOW IS FOR OFFICE USE ONLY.

Plan Enrolled As: SABC Standard ☐ Initial Only ☐ Self ☐ Agent ☐ _____

(Special Note: All Other Agent/Groups must sign a Business Associate Agreement and are required to complete SABC Cafeteria Plan training.)

Changes for Plan:		
Group Rolled:		
Date:	Who Set Up or Rolled:	New Plan Year Pay Mode:
Old Check #	New Check #	1st Pay Date:
DC Balance $	URM Balance $	Check Minimum Reset/Balances Verified ☐

FOR DATA REQUIREMENTS TO SET UP YOUR CAFETERIA PLAN, PLEASE READ THE ATTACHED.

SABC MUST HAVE THE FOLLOWING INFORMATION FOR DOWNLOAD:

GENERAL EMPLOYEE CENSUS OF REQUIRED INFORMATION:

SOCIAL SECURITY NUMBER,
NAME: LAST,
FIRST,
MIDDLE INITIAL
ADDRESS 1:
ADDRESS 2:
CITY:
STATE:
ZIP:
DATE OF BIRTH:
DATE OF HIRE:
PAY FREQUENCY: (example Monthly)
(BY *HOW EMPLOYEE IS PAID, MONTHLY, SEMI-MONTHLY, WEEKLY, BI-WEEKLY*)
NUMBER OF DEUCTIONS: (12 ETC.)
GROSS PAY: (LIST AMOUNT BY *HOW PAID, EXAMPLE MONTHLY, SEMI-MONTHLY, WEEKLY, BI-WEEKLY*)
LOCATION NUMBER: IF YOU HAVE SEVERAL LOCATIONS, OR AS AN IDENTIFIER FOR A DIFFERENT DEPARTMENT OR CLASS.
(*PLEASE PROVIDE LIST OF LOCATIONS AND MATCHING ID NUMBER*)

LIST INSURANCE PRODUCTS BY TYPE: Health, Dental, Vision, etc.
(List Amounts by how they are deducted.)
EXAMPLE: MONTHLY, SEMI-MONTHLY WEEKLY, BI-WEEKLY

(EXAMPLE) (Be sure to include amount of product, by how deducted)
HEALTH- $40.00 Bi Weekly (*Only list portion paid by Employee*)
DENTAL
VISION
CANCER
INTENSIVE CARE
HOSPITAL INDEMNITY
MEDICAL SUPPLEMENT

Please provide name of the product carrier, i.e., Example STATE Health = Blue Cross/Blue Shield, and please indicate if products are not deducted the same way the employees are paid. (Example: *Employee paid 26 times a year, deductions are 24 times a year*.)

Please send a copy of each insurance billing listed as a deduction, so SABC may determine cafeteria plan eligibility of the product.

When completing this form.
Please contact Valerie Givens, with SABC @ 601-856-9933,
She will help you go thru the form faster.