Section 125
Cafeteria Plan Data Form

beneliance

Service(s) Requested

Check the benefits to be offered under this Plan:

- ☐ Core Health Benefits 5.1
- ☐ Non-Core Supplemental Health Benefits 5.2
- ☐ Health Care Premium Reimbursement (HCPR) 5.10
- ☐ Limited Purpose FSA – Dental and Vision Only 5.11
- ☐ Medical FSA 5.7
- ☐ Dependent Care FSA 5.8
- ☐ Health Savings Accounts 5.12

Division(s)

_____

Plan Elections

Legal Plan Name _____ Plan Effective Date _____/_____/_____

Length of Run Out Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other _____

Adopting the optional Carryover? ☐ Yes ☐ No Maximum Carryover (IRS MAX): _____

If not adopting Carryover, are you instead adopting the optional 2½-Month Grace Period? ☐ Yes ☐ No

Plan Year (date range)_____

Short Plan Year? ☐ Yes_____ ☐ No
(If Yes, specify date range for short plan year)

Current Plan

Do you currently have a 125 plan? ☐ Yes ☐ No (If No, please skip to Eligibility Requirements section)

Effective date of original plan _____

Health FSA* Minimum $_____ Maximum $_____

Dependent Care Assistance* Minimum $_____ Maximum $_____

Is this a mid-year take over? ☐ Yes ☐ No

Do you currently have a 2½-Month Grace Period? ☐ Yes ☐ No

Length of current Run Out Period (in days) _____

Who will administer the Grace and Run Out periods?_____

Benefits Term after Termination: ☐ End of Month ☐ Date of Termination ☐ Other _____

Length of Run Out Period after Termination (in days) _____

Debit Card

Do you want to incorporate the Debit Card into your plan? ☐ Yes ☐ No

If Yes, do you want to have your logo imprinted on the card? ☐ Yes ☐ No

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Contribution Schedule

Are all the employees paid on the same schedule? ☐ Yes ☐ No Number of deductions per plan year_____

The employees are paid as following (enter as many frequencies as are needed)

☐ Weekly First pay date after plan effective date _____

☐ Biweekly - 24* First pay date after plan effective date _____

☐ Biweekly - 26 First pay date after plan effective date _____

☐ Semi-Monthly First pay date after plan effective date _____

☐ Monthly First pay date after plan effective date _____

☐ Other _____

Deductions are taken: ☐ Each time the employee is paid, or ☐ _____

*List pay period(s) in which deductions are not taken, if any _____

Contributions Posting

☐ Assumed (No reports/files submitted for reconciliation)

☐ Posted Like Assumed, But Then Reconciled
(Posted on time whether or not reports/files received, then reconciled and postings adjusted as needed once we receive reports/files from group)

☐ Reconciled (No posting done until contributions reports/files received from group)

Plan Co-Pays

Medical Carrier Name:_____

Medical Address/Contact: _____

Health/Major Medical Plan – Office Visit $_____

Health/Major Medical Plan – Specialist Visit $_____

Health/Major Medical Plan – Emergency Room/Urgent Care Visit $_____

Health/Major Medical Plan – Other (Specify) _____ $_____

Prescriptions (Include All Tiers) $_____ / $_____ / $_____

Prescriptions (Include All Tiers) $_____ / $_____ / $_____

Other (Specify) _____ $_____

Other (Specify) _____ $_____

Reimbursement Frequency

Reimbursements for claims will be issued:

☐ Daily (Claims are processed and paid on the business day following the business day on which received)

☐ Weekly _____ ☐ Per Pay Period ☐ Monthly ☐ Other_____
(specify day of week) (specify)

Reimbursement Methods

☐ Healthcare debit card

☐ ACH deposit

☐ Checks (additional charges may apply)

If Check is selected, fill out the following:

Print Name: _____

Signature (to be placed on checks): _____

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COBRA Administrator

☐ N/A ☐ Employer (Self administered)

☐ DataPath Administrative Services ☐ Other (Specify) _____

Eligibility Requirements

The following class of employees is eligible:

☐ All ☐ Salaried Employees Only ☐ Hourly Employees Only ☐ Other

NOTE: Tax penalties may be imposed if the Plan contains eligibility requirements that have the effect of favoring highly compensated employees. Consult your tax advisor before limiting participation in the Plan.

The following employees are excluded from participation:

☐ No exclusions

☐ Exclusions:

☐ Required working hours per week ☐ Employees under the age of_____

☐ Union employees (unless the bargaining agreement provides for coverage)

☐ Non-resident aliens ☐ Other_____

NOTE: Section 125 does not specifically provide for election exclusions. Consult your tax advisor before excluding any classification(s) of employees.

The service period employees must complete before being eligible to participate is as follows:

☐ As of date of hire ☐ Days after date of hire_____ ☐ Months after date of hire_____

☐ Not Eligible if Employed less than_____Months ☐ Other_____

Once the employees are eligible, they can begin participating in the plan:

☐ Date employee becomes eligible ☐ First day of pay period

☐ First day of month ☐ First day of quarter

Additional Services

Filing of 5500 forms if employer has over 100 participants: ☐ Yes ☐ No

Discrimination Testing (Please fill out additional form): ☐ Yes ☐ No

Discrimination testing is required. If NO is checked, you are agreeing to complete these tests on your own or through another agency. If requested, Beneliance will perform these for you at the beginning of each Plan Year.

Wrap Document and Summary Plan Description (SPD): ☐ Yes ☐ No

Broker/Agent Name: _____ Agency: _____

Employer Signature: _____ **Date:** _____ /_____ /_____
mm/dd/yy

DataPath Signature: _____ **Date:** _____ /_____ /_____
mm/dd/yy

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