Employer Application
Section 125/Cafeteria Plan

EMPLOYER INFORMATION

Company Name: ______________________________ Phone: ____________

Street: ______________________________ Fax: ____________

City: ______________ State: ____________ Zip: ____________

Employer's Taxpayer Identification Number: ______________________________

Contact Name: ______________ Title: ______________

Contact Phone: (____) ______________ Contact E-mail: ______________

Do you currently have a Health Reimbursement Arrangement? ☐ Yes ☐ No If yes, administered by ______________

The following affiliated employers will adopt this Flexible Spending Arrangement as Participating Employers (if there is more than one, or if Affiliated Employers adopt this after the date the Adoption Agreement is executed, attach a list to this Adoption Agreement of such Affiliated Employers including their names, addresses and taxpayer identification numbers):

☐ N/A
☐ Name of Affiliated Employer (s):

____

____

If there are multiple employers, should there be separate billings for each location?
☐ Yes ☐ No

Type of Entity

☐ Corporation (including Tax-exempt or Non-Profit Corporation)
☐ S Corporation
☐ Limited Liability Company that is taxed as:
- ☐ A partnership or sole proprietorship
- ☐ A Corporation
- ☐ An S Corporation

☐ Sole Proprietorship or Non-Profit Corporation
- ☐ Partnership (including Limited Liability)
- ☐ Governmental Entity

☐ Other: ______________

Note: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Flexible Spending Arrangement.

PLAN SETUP INFORMATION/ARRANGEMENT OPTIONS

Effective Date ______________
☐ New FSA
☐ Renewal FSA
☐ Other: ______________

Plan Year Dates __________ to __________

Premium Conversion
☐ Employer-sponsored Health Insurance
☐ Employer-sponsored Dental Insurance
☐ Employer-sponsored Vision Insurance
☐ Group Term Life
☐ Other: ______________

Premium Conversion Election
☐ Initial enrollment by application, negative election thereafter
☐ Other: ______________

Flexible Spending Accounts
☐ Dependent Care
☐ Medical Expense Reimbursement
$__________ Annual Minimum
$__________ Annual Maximum

Plan Number assigned by the Employer
☐ 501
☐ 502
☐ 503
☐ Other: ______________

Employee applications and claims cannot be processed until we receive your payroll schedule. Therefore payroll schedule(s) must be attached indicating payroll dates.

The Payroll Schedule(s):
☐ Attached

Claims Payment
☐ Direct Deposit/ACH (recommended)
☐ Paper Check

ADMINISTRATIVE OPTIONS FOR FLEXIBLE SPENDING ACCOUNT ONLY

IRS Notice 2005-42 – 2 ½ month grace period

☐ I would like to allow for the grace period of medical and/or dependent care expenses up to 2 ½ months after the end of the Flexible Spending Account Plan Year.

I would like the following **grace period**:	☐ 2 ½ months	☐ Other ________________________
The grace period applies to the following:	☐ Medical/Dependent Care	☐ Medical only (recommended)
I would like the following **run-out** period:	☐ 90 days	☐ Other ________________________
I would like our run-out period to:	☐ Run concurrent with the grace period (recommended) ☐ Begin after the grace period	

☐ I **do not** want to incorporate the extension of the 2½ month grace period for reimbursement of health and dependent care expenses of the Flexible Spending Account Plan.

COBRA Administration

☐ I would like Sanford Health Plan to administer our COBRA as it applies to our Flexible Spending Account plan.
☐ I prefer to administer the COBRA as it applies to our Flexible Spending Account plan.

Discrimination Testing

☐ I would like Sanford Health Plan to conduct discrimination testing as it applies to our Flexible Spending Account Plan. I understand that I will have to provide additional reports to Sanford Health Plan if I select this option. If my plan is found to be discriminatory, I understand that I will need to make the necessary adjustments to the elections to ensure that the plan becomes non-discriminatory.
☐ I prefer to conduct the discrimination testing as it applies to our Flexible Spending Account plan.

ELIGIBILITY REQUIREMENTS

Open Enrollment Period ______________________ **Current Number of Eligible Employees** ___________________________

Conditions of Eligibility

☐ No exclusions
☐ All employees who customarily work, excluding overtime, at least _____ hours per week/year
☐ Other: ____

Any Eligible Employee will be eligible to participate in the Flexible Spending Arrangement upon satisfaction of the following:

☐ Date of Hire (no service required)
☐ _____ years after date of hire
☐ _____ months after date of hire
☐ _____ days after date of hire
☐ Other:________

Effective Date of Participation

An Eligible Employee who has satisfied the eligibility requirements will become a Participant on:

☐ The day on which such requirements are satisfied
☐ The first day of the month following the date on which such requirements are satisfied
☐ The first day of the pay period following the date on which such requirements are satisfied

Termination Date of Participant

A participant who no longer satisfies the eligibility requirements of the plan will terminate on:

☐ The date of termination
☐ The last day of the month in which the termination occurred
☐ Other_______________________________________

DISCLAIMER/SIGNATURE

We, the undersigned employer, affirm the accuracy of this application and acknowledge that this application can be relied upon for the preparation of the Flexible Spending Arrangement/Plan with Sanford Health Plan and may be used in preparation of the Summary Plan Description and/or Plan Document. We also agree to indemnify Sanford Health Plan and hold Sanford Health Plan harmless against claims for any and all loss, damage or lawsuits brought against Sanford Health Plan to recover benefits under the plan, unless such actions arise out of the willful act or negligence of Sanford Health Plan.

Dated this _____day of _______________________, 20 ____

Employer: ____

By: ____

Agent's Name: ____________________________________