

**CAFETERIA PLAN
DATA GATHERING FORM**

Name of Organization: _____
(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Employer ID No: _____ Date Incorporated/Organized: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address: _____ Zip: _____

Organization Type: Corporation. Sub-chapter "S" Corporation
 Professional Corporation Professional Association
 Partnership Sole Proprietorship
 Government Agency LLC Limited Liability Company
 Other _____

NOTE: Only employees can participate in a cafeteria plan. Thus, while partnerships, sole proprietorships and Sub-chapter "S" corporations may sponsor cafeteria plans, the following cannot participate: sole proprietors, partners, and greater than 2% shareholders in Sub-chapter "S" corporations.

The Employer/Organization entity is operating pursuant to the laws of the State of _____.

Principal Business Activity Code: _____

Nature Of Business: _____

PLAN ELECTIONS

Plan No.: 501 _____ Plan Name: Section 125 Cafeteria Plan

Plan Begin Date: _____/_____/_____ Plan End Date: _____/_____/_____

Plan Effective Date: _____/_____/_____ First Year Effective Date: _____/_____/_____

ELIGIBILITY REQUIREMENTS

1. The following class of employees is eligible to participate:

- All Salaried Employees Only Hourly Employees Only
 Other _____

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.

2. The following employees are excluded from participation:

- No exclusions
 Part-time employees normally expected to work less than _____ hours a week
 Employees under the age of _____
 Union employees (unless the bargaining agreement provides for coverage).
 Non-resident aliens
 Other: _____

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

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

- For the initial plan year, any one employed on the Plan Effective Date and for subsequent Plan Years
- As of date of hire.
 - Number of days after date of hire: _____
 - Number of months after date of hire: _____
- For all plan years
- As of date of hire.
 - Number of days after date of hire: _____
 - Number of months after date of hire: _____

Employees must be in service or on the job as one of the eligibility requirements.

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

- Date employee becomes eligible.
- First day of pay period following the date employee becomes eligible.
- First day of month following the date employee becomes eligible.
- First day of quarter following the date employee becomes eligible.
- First day of Plan Year following the date employee becomes eligible.

BENEFITS

Check the benefits to be offered under this Plan:

- | | |
|--|--|
| <input type="checkbox"/> Core Health Benefits | <input type="checkbox"/> Cash Benefits |
| <input type="checkbox"/> Non-Core Supplemental Health Benefits | <input type="checkbox"/> Medical and Dental Expense FSA |
| <input type="checkbox"/> Group Term Life Benefits | <input type="checkbox"/> Dependent Care FSA |
| <input type="checkbox"/> Short Term Disability Benefits | <input type="checkbox"/> Vacation Purchase Program |
| <input type="checkbox"/> Long Term Disability Benefits | <input type="checkbox"/> Individually Owned Health Insurance |

CONTRIBUTIONS

Overall Maximum for all Benefits: \$ _____

Cannot be beyond reach of all employees. Rule of thumb: Do not exceed estimated annual salary of lowest paid eligible employee on the payroll which will be prorated for any Plan Year less than 12 months.

Medical/Dental: FSA: Minimum: \$ _____ Maximum: \$ _____

Dependent Assistance: Minimum: \$ _____ Maximum: \$ _____

Dependent Care contributions cannot exceed \$5,000 or, if Participant is married and filing separately, \$2,500.

REIMBURSEMENTS

Claims Closing Date: ____/____/____ Minimum Check Amount: \$ _____

Reimbursement checks for claims will be issued:

- Every payday _____ times a month. _____ days after claim is received.

Reimbursements must be paid at least once a month.

BENEFIT COORDINATOR

The Benefit Coordinator is the individual at the Employer to whom Employees should direct communications and inquiries.

Name: _____

Title: _____

Company Name: _____

Address: _____

City _____ State: _____ Zip: _____

Telephone _____ Alternate Phone: _____

e-mail _____ Website: _____

BANK ACCOUNT

Name of Bank: _____

Bank Address: _____

Bank City: _____ Bank State: _____ Bank Zip Code: _____

Name on Account: _____

Account Number: _____

Bank Routing No. (MICR) (Ex: 123456789): _____

Bank Routing No. (Bank Info) (Ex: 111-42/348): _____

Person Signing Check: _____

DEDUCTION AND PAYMENT LIMITATIONS

Are all the employees paid on the same schedule? Yes No

The employees are paid as following: (Enter as many frequencies as are needed.)

Weekly First pay date after effective date: _____

Biweekly First pay date after effective date: _____

Semi-Monthly First pay date after effective date: _____

Second pay date after effective date: _____

Monthly First pay date after effective date: _____

Other _____

The deductions are taken:

Each time the employee is paid, or
