TPA Systems Inc. Section 125 Cafeteria Plan Employer Questionnaire

employer name: _____ tax ID number: _____

full physical address: _____ phone: _____

full mailing address: _____ fax: _____

state of organization: _____ entity type: _____ fiscal year-end: _____

member of affiliated service group? _____ member of controlled group? _____ List affiliates if applicable:

_____

mgt contact info: name _____ phone _____ email _____

admin contact info: name _____ phone _____ email _____

Plan Information

Is there an in-force plan? _____ If yes, original eff. date: _____ original plan year: _____

eff. date of new plan: _____ date of new summary plan description: _____

Will new plan have a short plan year? _____ If yes, specify short period: _____

To designate whether expenses should be allowable in the plan, place an "x" in each available box where indicated:

employer group premiums: ☐ medical ☐ dental ☐ vision ☐ disability ☐ group term life

individual policy premiums: ☐ medical ☐ dental ☐ vision ☐ disability

expenses: ☐ medical ☐ limited purpose ☐ dependent care ☐ adoption ☐ HSA contributions

Eligibility

EXCLUDE as ineligible: ☐ leased employees ☐ union employees ☐ non-resident aliens

☐ P/T employees working less than _____ hours annually minimum age is ____ (max age is 21, "N/A" acceptable)

minimum total service requirement: ☐ none ____ hours ____ days ____ months ____ years

enrollment dates: ☐ immediate ☐ first of month ☐ first day of each plan quarter

☐ first day of first and seventh months of plan year ☐ first day of plan year

Auto-enroll participants in employer-sponsored plans? _____ Auto-adjust premium changes? _____

Allow non-terminated participants continued participation until plan year end upon loss of eligibility? _____

Automatically reinstate rehires within 30 days of termination and permit immediate new enrollment if rehired more than 30 days after termination? _____

IMPORTANT: Please complete the entire form. Leave no spaces blank!

Benefits

plan year annual health care maximum contribution: $_____ eligible participants:

☐ participants ☐ participant, spouse, and dependents ☐ participants covered under employer medical

name of company sponsored medical plan: _____

How should health care reimbursements coordinate with HSAs? ☐ leave unaddressed ☐ permitted coverage

☐ post deductible coverage ☐ both permitted and post deductible coverage

HRA/cafeteria plan coordination: ☐ leave unaddressed ☐ HRA first ☐ 125 first

Company contributions to plan: ☐ none ☐ at company's discretion ☐ 2% of compensation

☐ lesser of 6% of compensation or 100% match ☐ pursuant to a fixed method: _____

(cont.): _____

Participant election date: the ____ day period preceding the end of the plan year. Default if participant fails to elect:

☐ participant not enrolled ☐ previous elections continued ☐ premium conversions continued

election modifications allowed: ☐ whenever permitted by IRS ☐ pursuant to administrator procedures

contributions allowed while on leave under FMLA? _____ allowed under other leave of absence? _____

If "yes" to either, state any applicable conditions: _____

Allow dependent care spend-down? _____ effective date: _____

Plan Operations

claim filing deadline: active: _____ days after end of plan year; terminated: ____ days after termination date.

Will employer provide stored value cards? _____ Card limitations: _____

_____

Submit claims to: ☐ employer ☐ plan administrator: _____

Is plan COBRA eligible? _____ full COBRA notice contact info: _____

COBRA participant notification period for eligible events: _____ days after event

IMPORTANT: Please complete the entire form. Leave no spaces blank!