PURCHASER DETAILS

(1) CONTACT INFORMATION

Contact Name:		**Email *(required)*:**					
Title:		Telephone:					
Purchaser Name:		Business Federal ID#:					
Physical Address: *(no PO Box)*		City:		State:		Zip:	
Mailing Address:		City:		State:		Zip:	
Billing Contact Name: *(if different from primary contact)*		Email:					
Billing Mailing Address Name: *(if different from primary contact)*		City:		State:		Zip:	
NAICS/SIC Code:		Total # Employees:					
Nature of Business:		Total # Benefit Eligible Employees:					
Tax Filing Status:	❑ C-Corp ❑ S-Corp ❑ Partnership ❑ Sole Proprietor ❑ Non-Profit ❑ LLC ❑ Other:						
Health Insurance Carrier:		Carrier Group ID#:		Renewal Date:			
Carrier AM/Rep Name:		AM/Rep Email:					
Are you a *current* TASC Purchaser?	❑ No ❑ Yes	***If Yes***, please provide your 12-Digit TASC ID#:					

(2) SERVICE OFFERINGS & FEES

Select TASC Subscription Services, enter the proposed fees, and complete each corresponding section. Set-Up fee payments are due at the time of application submission. **(South Dakota residents add 4.5% sales tax; West Virginia residents add 6.0%.)**

Subscription Services:	One Time Set-Up Fees	Administration Fees	Minimum Admin Fee	Annual Renewal Fees	Additional Services and Fees
❑ **FlexSystem FSA**	$	$	$	$	$
❑ **FlexSystem POP**	$ n/a	$	$ n/a	$ n/a	$ n/a
❑ **TASC HSA**	$	$	$	$	$
❑ **TASC GiveBack**	$	$	$	$	$
❑ **TASC HRA**	$	$	$	$	$ ❑ TASC HRA Debit Card
❑ **TASC INTEGRATED FUNDED HRA**	$	$	$	$	$
❑ **TASC RETIREE FUNDED HRA**	$	$	$	$	$
❑ **TASC COBRA**	$	$	$	$	$ ❑ QB Takeover
❑ **TASC Retiree Billing**	$	$	$	$	$
❑ **TASC FMLA**	$	$	$	$	$ ❑ Eligibility Determination
❑ **TASC ACA Employer Reporting**	$	$	$	$	$ ❑ **TASC ACA Employer Reporting**

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❑ **TASC ERISA**	$		$		$		$		$	
❑ **TASC PCORI** (with TASC ERISA) ❑ **TASC PCORI** (w/out TASC ERISA)	$		$		$		$		$	
❑ **TASC Form 5500 Preparation**	$		$		$		$		$	
❑ **TASC Non-Discrimination Testing**	$		$		$		$		$	
❑ **TASC HIPAA**	$		$		$		$		$	
TASC SUITES *(Select one)*										
❑ **Suite 1**: ERISA, HIPAA, FMLA	$		$		$		$		$	
❑ **Suite 2**: ERISA, HIPAA, FSA	$		$		$		$		$	
❑ **Suite 3**: ERISA, HIPAA, COBRA	$		$		$		$		$	
❑ **Suite 4**: ERISA, HIPAA, COBRA, FSA	$		$		$		$		$	
❑ **Suite 5**: ERISA, HIPAA, COBRA, FMLA	$		$		$		$		$	
❑ **Suite 6**: ERISA, HIPAA, COBRA, FSA, FMLA	$		$		$		$		$	
❑ **Suite 7**: HIPAA, COBRA, FSA, FMLA	$		$		$		$		$	
❑ **Suite 8**: HIPAA, COBRA	$		$		$		$		$	
SUITE Add-On Offerings										
❑ **TASC ACA Employer Reporting** (S)	$		$		$		$		$	
❑ **TASC Form 5500 Preparation** (S)	$		$		$		$		$	
❑ **TASC Form 990 Preparation (FHRA)** (S)	$		$		$		$		$	
❑ **TASC Summary of Benefits and Coverage Document Preparation (FHRA)** (S)	$		$		$		$		$	
❑ **TASC Non-Discrim Testing** (S)	$		$		$		$		$	
❑ **TASC HSA** (S)	$		$		$		$		$	
❑ **TASC HRA** (S)	$		$		$		$		$	
❑ **Account Package**	$		$		$		$		$	
	TOTAL ADD-ON OFFERINGS TO BE BILLED									
TOTAL FEES:	$		$		$		$		$	

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(3) BILLING INFORMATION

Billing Options

❑ TASC Automatic Check Processing (ACH)[1] – *complete Banking Information below*
❑ Pay by Invoice
❑ Credit Card – ***only available for fees submitted with this Plan Application, not future billing.***
****FHRA funding TBD. May be to trustee.***

Billing Frequency

❑ Monthly -- ***only available with ACH funding (select above)***
❑ Quarterly
❑ Annually

Banking Information

This information will be used to process payments for services rendered.			
Financial Institution Name			
Bank Routing Number		**Bank Account Number**	

Account Funding

(TASC will initiate ACH debits from the bank account and financial institution named in the account funding section. Plan funding payments will be electronically deducted from the indicated bank account and automatically submitted on your scheduled payroll contribution dates.)

❑ Use same ACH information as banking information		❑ Use different ACH information as per below	
Financial Institution Name			
Bank Routing Number		**Bank Account Number**	

Credit Card Information

Credit Card information may **only** be used for Initial Setup Fees.			
Name on Card			
Card Type	❑ Visa ❑ MasterCard ❑ American Express ❑ Discover		
Card Number		**Expiration Date**	

[1]E-Pay is TASC's standard method for submission of *administration fees*. With E-Pay, TASC conveniently deducts your fees from your checking account. Simply complete the box above, signing where indicated. Please note ACH information for each benefit's plan funding will need separate attention in their respective section of the application. All written debit authorizations must agree that the Payer may revoke the authorization only by first notifying the Originator in the manner specified in the authorization. The language in the authorization represents the disclosure requirement associated with the clarification of OFAC economic sanction policies upon ACH Network Participants.

(4) AUTHORIZATION

This data and information is being provided to implement the Subscription Services purchased. This data and information is subject to the terms of the TASC USA, including TASC's reliance on its timeliness and accuracy.

⌦ **Purchaser Signature:** ______________________________ **Date:** ____________________

Title: ______________________________

Distributor/Agent Name:		**TASC Provider ID #:**		**Retail Code:**	
Primary Account Rep Name:		Email:			

INTERNAL USE ONLY: **Assist MyTASC ID:**	

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(5) BENEFIT ACCOUNT MANAGEMENT (BAM) OFFERINGS

(a) FlexSystem FSA

NEW Plan:	Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____
Existing Plan:	Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____
❑ **Mid-Year Plan Takeover**		❑ **POP Plan**	❑ Limited Purpose FSA (LPFSA)	❑ LPFSA Needed? ❑ Mirror the full FSA?

FlexSystem Benefit Account Offerings (select all that apply)

❑	Healthcare FSA – Medical Expense Reimbursement Account	Maximum	
❑	Dependent Care FSA Reimbursement Account	Maximum	
❑	Transit Reimbursement Account	Maximum	
❑	Parking Reimbursement Account	Maximum	
❑	Medical or Medical Related Premium		
❑	Non Employer Sponsored Premiums		
❑	Voluntary/Group Term Life Insurance Premium		
❑	Disability Insurance Premium		
❑	Supplemental Insurance		

Plan Details

❑	Elect a terminal restricted card for your Transit and Parking accounts		
❑	Elect Rollover for Transit and/or Parking accounts	End date (180 default)	____/_____/_____
❑	Elect Healthcare FSA Carryover	Amount	
❑	Elect a Grace Period *(not available with Carryover)*	End date *(75-day maximum)*	____/_____/_____
❑	Elect a Runout Period	End date	____/_____/_____
❑	Offer Employer Sponsored Group Health Insurance to employees		
❑	Additional Payroll Schedules *(If checked, attach additional payroll schedules.)*		

Funding

Number of Contributions in a 12-month Plan Year			
Payroll/Funding Cycle	❑ Weekly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Monthly ❑ Other _______________		
First Contribution Date	____/_____/_____	Second Contribution Date	____/_____/_____
Last Contribution Date	____/_____/_____		
POC Funding	❑ Yes ❑ No	*If yes, an POC Addendum and paperwork is required.*	

Participant and Eligibility Requirements

Entry and Probationary Period: Select the employment requirement below that an eligible employee must meet in order to enroll in the FlexSystem Plan at open enrollment, or at the time of hire.

❑	On the date of hire	❑	First of the month after date of hire
❑	30 days after date of hire	❑	First of the month after 30 days of continuous employment
❑	60 days after date of hire	❑	First of the month after 60 days of continuous employment
❑	90 days after date of hire	❑	Other: ___________________________________

Additional Requirements *(select all that apply)*

Included	Excluded	N/A	
❑	❑	❑	Members of bargaining units
❑	❑	❑	Part-time employees regularly scheduled to work at least ____ **hours** per week

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❑	❑	❑	Seasonal employees regularly working at least ____ **months** within a year
❑	❑	❑	Employees under ____ **years** of age

(b) TASC HSA

Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____

HSA Benefit Account Offerings	
❑	TASC HSA
❑	TASC HSA – LIMITED
❑	TASC HSA - PLAN ONLY

Funding				
Payroll/Funding Cycle	❑ Weekly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Monthly ❑ Other _______________			
Participant Contribution Schedule	*Dates applied to Participant accounts based on above selected payroll cycle.*			
	First Contribution Date	____/_____/_____	**Second** Contribution Date	____/_____/_____
	Last Contribution Date	____/_____/_____		
Employer Contributions	❑ Yes ❑ No ***If Yes,*** please complete all information below:			
Contribution Amount per Coverage Level	Single: $		Family: $	
Frequency of Employer Contributions	❑ One time	Contribution Date:		
	❑ Weekly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Monthly ❑ Other _______________			
Employer Contribution Schedule	First Contribution:	___/___/____	Second Contribution:	___/___/____
For banking holidays, select one option:	❑ Apply contributions ***next*** business day		❑ Apply contributions ***prior*** business day	
Pro-Rated for Mid-Year Enrollees	❑ Yes ❑ No		***If Yes***, select a method below:	
	❑ As of Plan Start Date	❑ As of Most Recent Quarter	❑ Other:____________	

(c) TASC GIVEBACK

Plan Start Date	____/_____/_____

Benefit Account Offerings (select all that apply)			
❑	Company Match →	Employee Match per Employee Per Year	
		Employee Match Per Payroll	
❑	Company Enrollment Bonus →	Bonus Amount	
❑	Hold a Fundraiser		

Funding			
Number of contributions in a 12-month Plan Year			
Payroll/Funding Cycle	❑ Weekly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Monthly ❑ Other _______________		
Employer Contributions	❑ Yes ❑ No ***If Yes,*** please complete all information below:		
First Contribution Date	____/_____/_____	Second Contribution Date	____/_____/_____
Last Contribution Date	____/_____/_____		

(d) TASC HRA

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Plan Start Date	____/_____/_____	❑ HRA Full Administration	❑ HRA Self-Administration

Plan Information			
Estimated Number of Participants:		Number of Employees (FT+PT)	
Existing HRA Plan in Place?	❑ No ❑ Yes	**If YES,** please provide the following information:	
ERISA 3-Digit Plan #:			
# of Current Participants:			
Name of Current Administrator:			
Current Run-Out Period:	______ Days		
Who will administer current Plan Runout?	❑ Prior Administrator	❑ TASC	
Roll Over/Carry Over:	❑ No ❑ Yes	If yes, maximum $ to rollover	

Single:		Family:		Comments:	

Plan Start

Select and complete one of the following two options. Indicate the Plan Year dates and when TASC HRA administration begins. HRA Plan Year should match the medical plan year if applicable.

❑ **New HRA Plan** *(no current plan exists)*	**1st Year Administration**	**2nd and Successive Years**
Plan Start Date:	First day of: ____/____ (mo/yr)	First day of: ____/____ (mo/yr)
# Consecutive Months Continued:		Twelve (12) month period
	Note: Plans need not run on the calendar year (i.e. January 1 - December 31)	

❑ **Mid-Year Plan Takeover** – *select one setup option below (Year-to-Date balances **must** be submitted with enrollments in order to be entered):*

❑ Full Plan Year setup; or	*Plan Sponsor must submit an aggregate balance report of participant claims paid year-to-date to adjust the Participant HRA balance*
❑ Short Plan Year setup: *(less than 12 months)*	*Plan Sponsor must submit an aggregate deductible credit report of participant claims paid year-to-date to adjust the Participant HRA balance. Allows you to extend a deductible credit to your Participants based on the amount of the health insurance deductible that has been satisfied thus far.*

Enter plan dates based on your selected setup:	**Plan Start Date**	**Plan End Date**
Current TPA Plan:	___/___/___ (mo/dd/yr)	___/___/___ (mo/dd/yr)
TASC HRA Plan:	___/___/___ (mo/dd/yr)	N/A

HRA Benefit Account Offerings

❑	Retiree HRA
❑	QSEHRA
❑	Integrated HRA

Health insurance carrier name	
Health insurance deductible individual	
Health insurance deductible family	

Participant and Eligibility Requirements

Select on eligibility requirement below:

❑ Eligibility requirements include participation in the named Health Insurance Plan (N/A for QSEHRA Plans); or
❑ Eligibility requirements include (select all that apply below):
- ❑ Part-time employees working at least ____ hours of work per week will be included (maximum 29 hours)
- ❑ Current employees completing ____ months of service with the employer will be included (maximum 90 days)
- ❑ New employees completing ____ months of service with the employer will be included (maximum 90 days)

Benefit Account Reimbursement Options (select all that apply)

❑	Medical deductible	❑	Dental
❑	Prescription	❑	Vision

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❑	Co-insurance	❑	Ortho
❑	Uninsured Medical	❑	213(d) - (Premiums not included)
❑	Co-Pays	❑	Individual Medical Premiums
❑	Individual Dental Premiums	❑	Individual Vision Premiums

Plan Type (select only ONE option)

❑	Family Aggregate: expenses can be shared by family members
❑	By Member: (Embedded Deductible)

TASC HRA Plan Participant Responsibility (amount participant is responsible for prior to reimbursements)

Individual Maximum: $		Family Maximum: $	

TASC HRA Employer Reimbursements	Percentage		Dollar Amount Range				TASC HRA Employer Reimbursed Amount	
Regulatory Limits for QSEHRA: Please consult your sales staff for the yearly regulatory limits for QSEHRA single and family		%	$	-	$		$	
		%	$	-	$		$	
		%	$	-	$		$	
		%	$	-	$		$	
	Minimum reimbursement **per individual:**						$	
	Maximum reimbursement **per family:**						$	

To fund your TASC HRA Plan, TASC will initiate ACH debits from the financial institution and bank account named below.

Funding Options	❑ Monthly Budgeted (ACH or Invoice)	❑ Point of Claims (ACH Only and Premium Services Bid Request Required)

Bank Information:	❑ Use same ACH info from this Application ❑ Use different ACH information as per below		
Financial Institution Name:		Branch:	
Bank Routing Number (9 digits):		Checking Account #:	

ADMIN ONLY: TASC HRA - Special Instructions: ____
Funding: _____ % (Minimum of 25%) ____

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(6) CONTINUATION OFFERINGS

(a) TASC COBRA

Plan Start Date	_____/______/______	*Plan Application must be received by 15th of month prior to this start date. COBRA Addendum is needed if requested plan start date does not meet this requirement.*

Number of Takeover Qualified Beneficiaries (TQBs):		Number of Employees On Health Insurance Plan	

COBRA Benefit Account Offerings (select all that apply)

❑	Include Takeover Qualified Beneficiaries (TQBs). ***If selected***, please include TQB forms for each beneficiary.
❑	Include Additional Subsidiaries, Affiliates, or Divisions under TASC COBRA. ***If selected***, complete boxes below:

Qualifying Events

When a COBRA Qualifying Event occurs, select when you would like the COBRA period to begin:

❑	First of the month, following the qualifying event	❑	Other:
❑	Day after the Qualifying Event		

Additional COBRA Services (fees apply)

❑	Carrier Notifications	❑	Other:
❑	Custom Reporting		

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(b) TASC RETIREE BILLING

Plan Start Date	____/_____/_____	*Plan Application must be received by 15th of month prior to this start date. COBRA Addendum is needed if requested plan start date does not meet this requirement.*
Number of Participating Retirees		

Retiree Billing Benefit Account Offerings (select all that apply)

❑	Include Takeover Qualified Beneficiaries (TQBs). ***If selected***, please include TQB forms for each beneficiary.
❑	Include Additional Subsidiaries, Affiliates, or Divisions under TASC Retiree Billing. ***If selected***, complete boxes below:

Identify all subsidiaries, affiliates, or divisions to include under TASC Retiree Billing and if they require a separate set-up for service communications:

NAME		SEPARATE	NAME		SEPARATE
1		❑	3		❑
2		❑	4		❑

Qualifying Events

When a COBRA Qualifying Event occurs, select when you would like the Retiree Billing period to begin:

❑	First of the month, following the qualifying event	❑	Other:
❑	Day after the Qualifying Event		

Additional Retiree Billing Services (fees apply)

❑	Carrier Notifications	❑	Custom Reporting
❑	Other:		

(c) TASC FMLA

Plan Start Date (Plan must start on the 1st of the month. Application must be received at least 5 business days before the requested start date.)	____/_____/_____
Do you have employees currently on FMLA leave?	❑ Yes ❑ No
If yes, how many employees are currently on FMLA leave?	
Does your company policy run FMLA concurrent with worker's compensation and short-term disability plans?	❑ Yes ❑ No
Which method of reporting do you use for FMLA hours?	❑ Manual reporting via online form ❑ Data feed *(via recurring file from your timekeeping system)*
Which 12-month FMLA tracking type does your company policy outline?	❑ Rolling Backward ❑ Rolling Forward ❑ Calendar Year ❑ Plan Year with Start Date of: ____/_____/_____
In what states do you have locations in?	
Do you have any locations that are not eligible for FMLA?	❑ Yes ❑ No

Additional Services (fees apply)

❑	Eligibility and entitlement determination (free with TASC Suite)	❑	Other:

Identify all subsidiaries, affiliates, or divisions to include under TASC FMLA and if they require a separate set-up for service communications:

NAME		SEPARATE	NAME		SEPARATE
1		❑	3		❑
2		❑	4		❑

(7) COMPLIANCE OFFERINGS

(a) TASC ACA EMPLOYER REPORTING

Plan Start Date - Must be a calendar year - please indicate the calendar year in which you want reporting to start	____/_____/_____

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Health Insurance Renewal Date	_____/______/______

	Employer Type (Select One)
❑	Single ALE (Applicable Large Employer) (one EIN)
❑	Aggregated ALE (more than one EIN)
❑	Non-ALE (under 50 fulltime employees)

	Applicable Large Employer Status (ALE) (Select One)
❑	ALE with fully insured medical plan
❑	ALE with self-insured medical plan
❑	Non-ALE with self-insured medical plan (1094B and 1095B Filing)
❑	ALE with fully insured and self-funded plans running congruently

Controlled Group

Please indicate if you are a member of <u>any</u> of the following (required): • a Controlled Group of business entities under IRS Section 414(b) or (c); • an affiliated service group under IRS Section 414(m); OR • an arrangement described under IRS Section 414(o)	❑ Yes (see below) ❑ No

Government Entity

Are you a Government Entity that has reportable employees under more than one EIN number?	❑ Yes (see below) ❑ No

If you answered YES to either question above, please complete the information in the section below for each member entity within the Aggregated ALE, placing the entity with the most employees on top, descending to the entity with the fewest employees. A plan application must be submitted separately for each entity.

Entity's Legal Name	**Entity's EIN Number**

	Additional Services (Fees apply)
❑	Minimum essential coverage offer indicator
❑	Variable hour tracking

(b) TASC ERISA

Plan Start Date	The ERISA contract will be effective the first of the month in which the application is received.

Plan Information (select all that apply; if no, leave blank)

	Yes	No
Is Entity Part of: - A controlled Group of Corporations under Code Section 414(b) - A group of Businesses/Trades under common control under Code Section 414(c); or - An Affiliated Services Group under Code Section 414(m)	❑	❑
Are benefits/premiums paid from a single source? (If No, separate applications are required)	❑	❑
Under PPACA, is your current Group Health Plan considered Grandfathered?	❑	❑
Are you considered an Applicable Large Employer (ALE) under the Employer Shared Responsibility Provision of the Affordable Care Act (ACA)?	❑	❑
Do you currently track employee hours to determine if any variable hour, part-time, or seasonal employees are fulltime employees for purposes of health plan eligibility?	❑	❑

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Do you offer Medicare Part D coverage? ***If Yes***, please select one of the following: ❑ Creditable ❑ Non-Creditable ❑ Both	❑	❑

Please complete the following information.

A	B Contract Year (mo/dd/yr)	C Benefit Contract Written to Group (G) or Individuals (I)	D Pre-tax Benefit (Y/N)	E Insurance Carrier or Service Provider name	F Is Benefit Self-Insured (SI) or Fully-Insured (FI)	G Total Number of Covered participants *(not including Dependents)*
Health						
Dental						
Vision						
Life						
AD&D						
STD						
LTD						
Voluntary/Supplemental Life or AD&D						
Wellness						
Employee Assistance Program						
Stop Loss Insurance						
Voluntary Products						
Other ERISA Plans						

Additional Services (additional fees may apply)

❑	Medicare Part D Notice	❑	Professional Services (billed hourly)
❑	Additional Benefit Plans (9+)	❑	Form 5500 Late Filing
❑	Carrier Certificates of Coverage attached to Plan Document	❑	PPACA Notices
❑	Wrap Document – Individual/Separate Affiliated Employer		

(c) TASC PCORI

Plan Start Date - Stand Alone PCORI will start 07/01, please indicate the year in which you would like reporting to start.	____/_____/_____

Current Benefits Status (select all that apply)

❑	A - Health Reimbursement Arrangement (HRA)
❑	B - TASC HRA Purchaser
❑	C - TASC Non-Excepted Health Flexible Spending Account (NEFSA) Purchaser
❑	D - Self-Insured Health Plan
❑	E - TASC Self-Administered HRA or NEFSA Purchaser

Participant Counts

As of the first day of the FIRST month of the plan year:	
As of the first day of the FOURTH month of the plan year:	
As of the first day of the SEVENTH month of the plan year:	
As of the first day of the TENTH month of the plan year:	

INSTRUCTIONS FOR PARTICIPANT COUNT

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If you selected A only, A and E, or C and E: Participant counts should equal the number of HRA or NEFSA plan participants on the first day of each quarter of the plan year.

If you selected A and D or C and D: Participant counts should equal the total number of self-insured health plan participants on the first day of each quarter during the plan year. Count each health plan participant with self-only coverage and then add to that the number of participants with other than self-only coverage multiplied by 2.35.

If you selected D only: Participant counts should equal the total number of self-insured health plan participants on the first day of quarter of the plan year. Count each health plan participant with self-only coverage and then add to that the number of participants with other than self-only coverage multiplied by 2.35.

If you selected A&B only and TASC administered your HRA in the previous year, TASC has the necessary counts. If TASC did not have administer your HRA in the previous year, please provide the appropriate counts.

(d) TASC FORM 5500 PREPARATION

Plan Start Date	____/_____/_____		
Do you have Late Filings for Form 5500?	❑ Yes ❑ No	***If Yes***, enter the number of late filings:	

NOTE: This service offering is for ongoing 5500 plans only, not for customers who are getting 5500 preparation with another offering. If you need a late filing only, please select under TASC ERISA service offering.

Is Entity Part of: - A controlled Group of Corporations under Code Section 414(b) - A group of Businesses/Trades under common control under Code Section 414(c); or - An Affiliated Services Group under Code Section 414(m) If Benefits/Premiums are NOT paid from a single source, separate applications are required.	❑ Yes	❑ Yes

(e) TASC NON-DISCRIMINATION TESTING

Plan Start Date - Please indicate the plan year to start testing	____/_____/_____
Controlled Group: Please indicate if you are a member of any of the following: (required) - A controlled Group of business entities under IRS Section 414(b) or (c); - An affiliated service group under IRS Section 414(m); or - An arrangement described under IRS Section 414(o).	❑ No ❑ Yes If yes, see below*

- If you selected "Yes" in the above question, please provide a list of all other companies and incorporated business entities.
- Indicate on this list which entity or entities' employees participate in the cafeteria plan and indicate the type of corporation for each entity (i.e., C-Corp, Subchapter S Corp, Partnership, etc.).
- Note: In general, all employees under a controlled group of employers are considered when performing Plan Non-Discrimination Testing.

Testing Options (select all that apply; fill in dates if applicable)

Yes	No				
❑	❑	**Do you need testing for a Premium Only Plan – Section 125 (POP)?**			
		Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____
❑	❑	**Do you need testing for a Healthcare Flexible Spending Account (FSA)?**			
		Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____
❑	❑	**Do you need testing for a Dependent Care Flexible Spending Account (FSA)?**			
		Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____
❑	❑	**Do you need testing for a Health Reimbursement Arrangement (HRA)?**			
		Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____
❑	❑	**Do you need testing for Self-Insured Medical Plans?**			
		Plan Start Date	____/_____/_____	Plan End Date	____/_____/_____
❑	❑	**Do you need testing for Group Life Insurance?**			

Purchaser Initials

		Plan Start Date	_____/______/______	Plan End Date	_____/______/______
Note: Group employees of all entities must be tested if entity is a member of a controlled group of corporations, trades, or businesses under common control or an affiliated service.					

SPECIAL INSTRUCTIONS