PREMIUM CONVERSION PLAN

ABPM REP:

Plan Document Checklist

1. NAME OF EMPLOYER

_____
(Exactly as it is to appear with punctuation)

2. EMPLOYER'S ADDRESS

_____
(Physical)

_____
(PO Box)

_____
(City) (State) (Zip)

Telephone _____

Fax # _____

3. CONTACT PERSONNEL

Human Resources: _____

HR Phone: _____

HR E-Mail Address _____

Payroll Department: _____

PR Phone: _____

PR E-Mail Address _____

Person Authorized to amend Plan:

_____
(Name) (Title)

4. EMPLOYER'S TAX ID NUMBER

_____

5. PLAN NUMBER

☐ 501 ☐ 504
☐ 502 ☐ 505
☐ 503 ☐ 506

6. PLAN INFORMATION

☐ New Plan
☐ Amendment and restatement

7. PLAN YEAR

Begins _____
(Month / Day) (January 1)

Ends _____
(Month / Day) (December 31)

Is first year a short Plan Year?

☐ Yes, beginning _____
(Month / Day) (May 1)

☐ N/A

8. EFFECTIVE DATE(S)

Initial effective date _____
(Month / Day / Year) (1/1/2020)

This restatement _____
(Month / Day / Year) (1/1/2020)

9. EMPLOYER ENTITY

☐ Corporation
☐ S Corporation **(2% shareholders not eligible)**
☐ Governmental Entity or Church
☐ Limited Liability Corporation
☐ Non-Profit Organization
☐ Partnership **(self-employed partners not eligible)**
☐ Sole Proprietorship **(self-employed not eligible)**

10. ELIGIBLE CLASS OF EMPLOYEES

☐ All Employees who satisfy eligibility requirements
☐ Salaried Employees only
☐ Hourly Employees only
☐ All Employees EXCEPT:
  ☐ Commissioned Employees
  ☐ Union Employees
  ☐ Leased Employees
  ☐ Part-time Employees, expected to work less than _____ hours per week
  ☐ Non-Resident Aliens
  ☐ Employees not eligible under the Employer's Group Medical Plan
  ☐ Other exclusion _____

11. CONDITIONS FOR ELIGIBILITY

☐ Same as Employer's group medical plan
☐ For first Plan Year only, anyone employed on the effective date of the Plan is eligible, thereafter: (Choose one from a-d below)
☐ For all years, eligibility is as follows: (Choose 1 below)

a ☐ Date of hire (No service required)
b. ☐ _____ days after date of hire
c. ☐ _____ months after date of hire
d. ☐ _____ years after date of hire

12. ENTRY DATE

☐ First day of pay period following date requirements were met (See #11)
☐ First day of month following date requirements were met as indicated in #11
☐ Date conditions for eligibility are met (See #11)
☐ First day of Plan Year following date requirements were met as indicated in #11
☐ Same as Employer's Group Medical Plan

13. FAMILY AND MEDICAL LEAVE ACT. Is the Employer subject to these provisions?

☐ Yes
☐ No

14. CONTRIBUTIONS. Plan will provide for

☐ Salary reduction contributions ONLY (No Employer contribution)
☐ Employer contributions ONLY (No salary reductions)
☐ Both salary reductions AND Employer contributions

15. EMPLOYER CONTRIBUTIONS
For each Plan Year, Employer will contribute

☐ N/A
☐ _____% of compensation per participant
☐ $_____ per participant
☐ Discretionary
☐ Other

AND the contributions shall be made

☐ At the beginning of Plan Year
☐ Pro rata each pay period

AND the contributions are convertible to cash?

☐ Yes
☐ No

AND the contributions made to:

☐ Health Savings Account (Q. 19.)
☐ Employee Premiums

16. PREMIUM PAYMENTS may be elected for

☐ Health insurance
☐ Dependent health insurance ONLY

PREMIUM PAYMENTS may be elected for

☐ Group Term Life Insurance
☐ Disability Insurance
☐ Dental Insurance
☐ Cancer Insurance
☐ Vision Insurance
☐ Accidental Death and Dismemberment Insurance
☐ Other

17. HEALTH PREMIUM PAYMENTS. Are the premium payments elected above self-insured by the Employer?

☐ Yes Provider: _____
☐ No

18. GROUP HEALTH PLAN CHANGE IN STATUS: Election revocation allowed for the following changes?

☐ Reduction in hours of service.
☐ Marketplace/Exchange participation.

19. IS A HEALTH SAVINGS ACCOUNT (HSA) PROVIDED BY THE EMPLOYER?

☐ Yes
☐ No

20. BENEFIT ELECTION PERIOD SHALL BE

☐ The _____ day period prior to each Plan Year.
☐ Established by administrator in a nondiscriminatory manner.

21. IS AUTOMATIC ENROLLMENT for insured benefits provided under this plan?

☐ Yes
☐ No

22. PARTICIPANTS WHO FAIL TO SIGN A NEW ELECTION FORM SHALL

☐ Be considered to have elected not to participate for upcoming Plan Year.
☐ Continue same elections as prior year.

23. WILL MORE THAN ONE COMPANY BE COVERED UNDER THIS PLAN?

☐ No or N/A
☐ Yes, include signature lines for:

_____
(Company Name)
_____
(Street Address)
_____
(City) (State) (Zip)
_____
(Tax ID Number)

24. ARE THERE SEPARATE DIVISIONS WITHIN THIS COMPANY?

☐ No or N/A
☐ Yes, include signature lines for:

_____
(Company Name)
_____
(Street Address)
_____
(City) (State) (Zip)
_____
(Tax ID Number)
(**NOTE:** Please attach additional affiliated Employer information)

25. FEES

	FEES
Initial Set-Up Fee	$_____
Annual Re-Enrollment Fee	$_____

26. BROKER NAME & ADDRESS

_____
(Name)
_____
(Company)
_____
(Address)
_____
(City) (State) (Zip)

E-mail Address _____

Telephone: _____

Fax: _____

Federal Tax ID# _____

These documents are being printed by Allegiance Benefit Plan Management, Inc., at the direction of the Employer named on the checklist form, under the supervision of an attorney. It is understood that Allegiance Benefit Plan Management, Inc., is not engaged in the practice of law. Any unanswered questions may result in errors in the Plan produced by using the information from this worksheet. I understand that in preparing the document requested, Allegiance Benefit Plan Management, Inc., is utilizing information shown on this checklist to produce legal documents using a format which has been designed by Allegiance Benefit Plan Management, Inc., with advice and assistance of its attorneys. Allegiance Benefit Plan Management, Inc., has made NO REPRESENTATION OR WARRANTY OF ANY KIND, expressed or implied, including no warranties of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, nor is any opinion, expressed or implied, rendered by its attorneys as to the legal effect, sufficiency or tax qualification of any document utilizing Allegiance Benefit Plan Management, Inc., format. It is understood and agreed that the documents must be reviewed and approved by the Employer's tax and legal counsel and that neither Allegiance Benefit Plan Management, Inc., or its attorneys and accountants are acting as legal or tax advisors to the Employer. I hereby RELEASE Allegiance Benefit Plan Management, Inc., and its attorneys from any and all liability attributable to any legal or other defect in the requested documents.

Prepared By: _____

(Revised December 2020)

1. Total number of Employees: _____
2. Total number of Employees eligible to participate: _____
3. Highly Compensated Employees:

_____

_____

_____

_____

_____

4. Key Employees:

_____

_____

_____

_____

_____

_____

_____

_____

DEFINITIONS:

HIGHLY COMPENSATED EMPLOYEE (HCE):

- An officer; or
- A shareholder owning more than 5% of the voting power or value of all classes of stock of the Employer; or
- Highly compensated based on compensation level, to mean an Employee who earns in excess of $120,000 in the prior Plan Year or, if elected by the Employer, who was in the 20% top-paid group; or
- A spouse or dependent of an individual described above.

KEY EMPLOYEE:

- An officer of the Employer with annual compensation greater than $175,000 (as indexed for cost-of-living adjustments); or
- A more-than-5% owner of the Employer; or
- A more-than-1% owner of the Employer with annual compensation in excess of $150,000 (not indexed).

CORPORATE HEADQUARTERS
PO Box 4346
Missoula, MT 59806
(406) 721-2222 or (877) 424-3570
Fax (406) 523-3149 or (877) 424-3539
www.askallegiance.com

OREGON OFFICE
PO Box 2930
Tualatin, OR 97062
(503) 885-1888
Fax (503) 885-1988