



PREMIUM CONVERSION PLAN 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 (If this is the first Flex Plan, check 501)

- 501
- 502
- 503
- 504
- 505
- 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) (1/1/2011)

This restatement _____
(Month / Day / Year) (1/1/2011)

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

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. **FOR HEALTH AND DISABILITY INSURANCE, may Participants seek reimbursement for individual policies through the Premium Conversion Plan?**
- N/A
 - Yes, at the Administrators discretion
 - No

19. **IS A HEALTH SAVINGS ACCOUNT 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. ~~8 C9 G'H<9'8 J-G-CB'F9EI -F9'5'G9D5 F5 H9'6 =@@~~
- Yes
 - No

26. **FEES**

	ABPM	AGENT	TOTAL
Initial Set-Up Fee	_____	_____	\$ _____
Annual Re-Enrollment Fee	_____	_____	\$ _____

27. **BROKER NAME & ADDRESS**
- _____
 (Name)
- _____
 (Company)
- _____
 (Address)
- _____
 (City) (State) (Zip)
- Telephone: _____
- Fax: _____
- Federal Tax ID# _____

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Signed _____

(Revised August 2010)

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;
- A shareholder owning more than 5% of the voting power or value of all classes of stock of the employer;
- Highly compensated based on compensation level, defined by Code § 125 414(q) to mean an employee who earns in excess of \$110,000 in the prior plan year or, if elected by the employer, who was in the 20% top-paid group; or,
- A spouse or dependent (within the meaning of Code § 152) of an individual described above.

KEY EMPLOYEE:

- An officer of the employer with annual compensation greater than \$160,000 (as indexed for cost-of-living adjustments);
- 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.allegianceflexadvantage.com

OREGON OFFICE

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