

# HR Concepts, LLC

"Your Third Party Administrator of Choice"

## Section 125 Employer Application (POP & FSA)

### Part I. Employer Information

Employer Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Tax Id #: \_\_\_\_\_

Primary Point of Contact: \_\_\_\_\_ Phone Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Point of Contact: \_\_\_\_\_ Phone Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Billing Point of Contact: \_\_\_\_\_ Phone Ext: \_\_\_\_\_ Email: \_\_\_\_\_

### Part II. Plan Description

Original Effective Date of Section 125 Plan: \_\_\_\_\_ Plan Year: \_\_\_\_\_ to \_\_\_\_\_

Short Plan Year: Yes / No If yes, indicate next plan year: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_ **Premium Offset Plan** (check those which apply)

\_\_\_ Health \_\_\_ Dental \_\_\_ Vision

\_\_\_ **Health Care Flexible Spending Accounts**

Maximum Election: \_\_\_\_\_ Minimum Election: \_\_\_\_\_ Employer Contribution: \_\_\_\_\_

\_\_\_ **Dependent Care Flexible Spending Accounts**

Maximum Election: \_\_\_\_\_ Minimum Election: \_\_\_\_\_ Employer Contribution: \_\_\_\_\_

2 ½ Month Extension: Yes/No

If the employer contributes – please describe the benefit:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Part III. General Administration Questions

Who handles the COBRA administration when an employee terminates: \_\_\_\_\_

List co pays for insurance (Example: ER, Dr visit, RX,etc.):

\_\_\_\_\_



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Phone: 603-647-1147 • Fax: 1-866-978-7868 • email: info@hrconcepts.biz

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## Part IV. Eligibility

<b>Premium Offset Plan</b> Hours: _____	Length of Service: _____
<b>Health Care Accounts</b> Hours: _____	Length of Service: _____
<b>Dependent Care Accounts</b> Hours: _____	Length of Service: _____
How Many Employees are Eligible: _____	Total Number of Employees: _____
Divisions of Employees: Yes/No <b>If Yes, list Divisions that need to be set up for reports:</b> _____	

## Part V. Tax Filing Information

Business Structure (Ex: S Corp, C Corp, LLC): _____	State Organized in: _____
Is this a Controlled Group: Yes / No <b>(If yes, fill in below)</b> (Majority owner of company also owns other company as majority owner)	
Employer 1 Name: _____	Number of Employees: _____
Address: _____	City: _____ St.: _____ Zip: _____
Tax Id#: _____	Business Structure: _____ State Organized in: _____

## Part VI. Payroll Information

Payroll Cycle (ex: weekly, Bi-weekly etc.): _____	1st payroll Reduction Day: _____
Number of payrolls this year: _____	Number of payrolls Next Year: _____
If short plan year this year	

## Part VII. Signatures and Fees

**Broker:**

**Circle if Broker Pays: Setup / Renewal / Admin**

Setup/Installation Fee: \$ _____	Account Fee: \$ _____	Minimum Billing/Employee/Month \$ _____
Annual Renewal Fee: \$ _____	Account Fee: \$ _____	Minimum Billing/Employee/Month \$ _____
Authorized Signature of ER: _____ Title: _____ Date: _____		
For internal use only: Account Executive: _____		



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