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.):

____

Flex Plans • HSA's • Commuter Plans • HRA's • Dental Plans • COBRA

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Part IV. Eligibility

Premium Offset Plan Hours: ________________ Length of Service: ______________________

Health Care Accounts Hours: _________________ Length of Service: ______________________

Dependent Care Accounts Hours: _____________ Length of Service: ______________________

How Many Employees are Eligible: _____________ Total Number of Employees: _______________

Divisions of Employees: Yes/No **If Yes, list Divisions that need to be set up for reports**:

____

Part V. Tax Filing Information

Business Structure (Ex: S Corp, C Corp, LLC): _________ State Organized in: ________

Is this a Controlled Group: Yes / No **(If yes, fill in below)**
(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: ____________

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