# BENEFLEX

## POP APPLICATION 0R
## PLAN DOCUMENT INFORMATION SHEET

**Beneflex Inc.**
**2505 21st Avenue South, Suite 450**
**Nashville, TN 37212**
**800-925-4087 • Fax 800-449-7501**

## SECTION A: General Information

1. Beneflex Control # (EIN): ______________________________

2. Plan Sponsor (company legal name): ______________________________

3. Business Address (mailing): ______________________________

4. Business Phone Number: ( ____ ) ____________________ Fax: ( ___ ) ____________________

5. Business Type (corporation, partnership, proprietorship): ______________________________

6. State of incorporation: ______________________________

7. Name of plan: ______________________________
(YOU MUST SPECIFY IF THIS IS A POP PLAN OR FLEX PLAN -Example: ABC Company Premium Only Plan)

8. Type of Plan (check one): ☐ a new plan effective as of: ______________________________
☐ an amendment and restatement of an existing Section 125 Plan.

• Original plan effective date: ______________ Amendment and reinstatement date: ______________

Note: POP application must be received at least 10 business days prior to requested effective date or amendment and reinstatement date.

## SECTION B: Definitions

1. First day of plan year: ____________________ Last day of plan year (must be 12-month period): ______________

2. An employee of the company regularly performing services at least __________ hours per week shall become a participant on the first day of the month coincidental with or next following the date the employee completes ______ days of consecutive employment.

3. Employees hired after a period of termination will become eligible for the plan on the first day of he month coincidental with or next following the date the employee completes _____days of consecutive employment, provided such date is not earlier than the first day of first plan year beginning after the employee's termination.

5. Employer **will** ☐ will not ☐ allow **post tax deductions** on Dependent Care FSA. Please check one box.
(Maximum Pre-tax allowed will be $5000). There is NO charge to the employer for post-tax deductions.

6. Employees **Maximum** Deduction Amount (**Med FSA Only**) $ ______________ Minimum $ ____________________

## SECTION C: Administration

Plan Administrative Contact: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________ Telephone: ( ___ ) ____________________

Signature: ______________________________ Date: ____________________

Title: ______________________________ Email address: ______________ @ ______________

FIRST PAYDATE OF PLAN: ______________________________

## SECTION D: Benefits Offered

Dependent Care: ☐ MedFSA: ☐ Transit: ☐ Parking: ☐

**Pay Cycle:** Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐

**Dependent Care FSA Method of Payment:** Beneflex Draft ☐ Employer Originated EFT ☐

Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Money must be in Beneflex Account by Wednesday for Daycare Provider to be paid on Friday**

**MedFSA**: Dollar Limit: Minimum $ ____________ Maximum $ ____________

**Reimbursement Account:** Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Fee Account:** Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Med FSA Fee Rates Per Participant Per Month $☐ . ☐☐

**Transit and/or Parking Reimbursement Account:** Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Fee Account:** Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Transit and/or Parking Fee Rates Per Participant Per Month $☐ . ☐☐

## SECTION E: Beneflex Agent Information

Agent Name: ____________ Agent #: ____________

Street Address: ____________

City, State, Zip: ____________ Telephone: ( __ ) ____________

Company: ____________ Date: ____________

Email address: ____________ @ ____________