SECTION 125 FLEXIBLE BENEFITS PLAN

PLAN DESIGN AND ADOPTION AGREEMENT

I. EMPLOYER DATA

Legal Name:			Fed Tax ID:
Street Address:			
Mailing Address:			
City:	State:	Zip:	Phone: ( )
Contact Person:			Fax: ( )
E-mail Address:			State of Incorporation:

Employer Entity:

_____ C Corp _____Partnership _____Nonprofit Corp _____Professional Service

_____ S Corp _____Church _____Sole Proprietorship _____Governmental Entity

_____LLC or LLP _____Tax-Exempt Org.

If the employer is part of a Controlled Group of Companies, list the legal names of the other companies here. Circle the names of affiliated employers who will adopt the Plan:

_____

_____

_____

II. PLAN INFORMATION

Plan #	Original Plan Effective Date	CPN Plan Effective Date	CPN Takeover Date	Plan Year Beginning	Plan Year Ending

NOTES: _____

_____

_____

III. CONTRIBUTIONS

_____ Employee Salary Reductions
_____ Employer Contributions: _____
_____ Electronic Funds Transfer (authorization required)

IV. ELIGIBILITY REQUIREMENTS

Employees in the following categories will be **excluded**:

_____ Part-time employees working less than _____ hours per week

_____ Under the age of _____ (not to exceed 21 years)

_____ Commission Employees

_____ Contract Employees

V. PARTICIPATION DATE

_____ First day of each month after _____ days of continuous employment (waiting period)
_____ The day after satisfying eligibility requirements.

VI. BENEFIT OPTIONS

INSURANCE PREMIUMS:

____ Group Term Life	____ Accident
____ Medical	____ Vision
____ Dental	____ Hospital Indemnity
____ Cancer	____ Intensive Care

FLEXIBLE SPENDING ARRANGEMENTS:

Account Type	Plan Year Maximum	Optional Minimum Age	Eligibility Service
____Medical Expenses ($2,650 IRS Maximum)			
____ Dependent Care ($5,000 IRS Maximum)			

_____ **Limited Purpose Healthcare FSA** (limited to vision and dental) subject to annual limit of $_____ (IRS Maximum $2,650), for use with HSA.

_____ **Adoption Assistance**

_____ **Tax-Free Parking and Transportation Program**

_____ **Employee Health Savings Account Contributions**

VII. ADDITIONAL CLAIM FEATURES

_____ Claims Extension Period of 2 ½ months

_____ $500 Carryover

(You **cannot** have the 2.5 month extension and the $500 Carryover. It is one or the other.)

VIII. CLAIMS REIMBURSEMENTS

Reimbursement checks will be:
_____ mailed directly to employee's address
_____ direct deposited to employee's account

Reimbursement Schedule Day: _____
(If left blank, a day of the week, Mon-Fri, will be chosen for you by CPN, Inc.)

Terminated employees will be allowed to file claims for a period of _____ days following date of termination.

Active Employees shall have _____ days ***after*** the end of each plan year to submit expenses against their prior plan year for dates of service that incurred during that eligibility period.

IX. DEBIT CARD FEATURE

☐ Check box to offer this option to your plan.

Debit Card Fee: $_____

Please indicate the claim type linkage you wish to be applied to the debit card:
☐ MEDICAL ☐ DENTAL ☐ VISION ☐ RX ☐ OTC *

*(There are limited OTC items that are considered qualified; most will require a written prescription from a licensed MD in order to be reimbursed. Or, in order to be purchased with the take care debit card, the OTC must be filled at a pharmacy counter and purchased as an RX (RX number to appear on the printed receipt).

INSURANCE CO-PAYS:

Medical Office Visit Co-Pays: _____
Prescription Co-Pays: _____
Emergency Room Co-Pays: _____
Dental Co-Pays: _____
Vision Co-Pays: _____

X. EXPENSE ALLOCATION

If the employer sponsors a Limited Healthcare FSA in addition to an HSA, eligible medical expenses are paid under the Healthcare FSA,

_____ *Before* the HSA

_____ *Commensurate with* the HSA

_____ *After* the HSA

XI. ELECTION CHANGES

Changes in election amounts are allowed at the beginning of each new Plan Year. The scope of these acceptable changes are detailed in Section 5.4 of the Plan Document. Any other options may be limited by legal or administrative restrictions.

XII. BENEFIT ELECTION OPTIONS

A. If an employee elects the eligible insurance benefits on payroll deduction, will you require an enrollment form in order to have that premium deduction set up on a pre-tax basis?

□ YES □ NO

B. FSA participants who fail to sign a new election form for subsequent Plan Years shall:

____ Continue same elections as prior year, or

____ Be considered to have elected not to participate for upcoming Plan Year

XIII. PAYROLL DIVISIONS

Payroll Frequency	First Deduction Date	2nd Deduction Date	# Deductions 1st Plan Year
10 12 24 26 52			
10 12 24 26 52			
Other:			

The completion of the attached Calendar (s) **must** be completed in full for each and every payroll your company has available. If you have more than one, please indicate each payroll cycle by color coding on the calendar provided.

Method of payment for FSA payroll contributions:

□ Employer will send via ACH to CPN

□ Employer accepts CPN to pull funds (appropriate document to be completed)

XIV. AUTHORIZATION

The Employer hereby agrees to the provisions of this Adoption Agreement, and in witness of its agreement, the Employer by its duly authorized officers, has executed this Adoption Agreement in this _____ day of _____, 20___.

EMPLOYER: _____

BY: _____
Authorized Officer Title

Note:
Corporate Planning Network, Inc., will not accept the responsibility for the accuracy of the administration and/or governmental filings for any plan year prior to your contract date with us. However, on a fee basis, we will prepare IRS reporting forms and are willing to assist you in any problem areas you may have with your past plan administration.

Doc Fee $_____

Compliance Fee $_____

Monthly Admin Fee $_____

Other: _____

Company Name: _____

SECTION 125 CAFETERIA PLAN

2018 Client Payroll Calendar

January 2018

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February 2018

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28			

March 2018

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April 2018

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May 2018

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

June 2018

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

July 2018

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

August 2018

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

September 2018

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

October 2018

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

November 2018

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

December 2018

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

If you have more than one pay cycle please **color** code and indicate below which color is for which payroll cycle.

Company Name: _____

SECTION 125 CAFETERIA PLAN

2019 Client Payroll Calendar

January 2019

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

February 2019

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

March 2019

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April 2019

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

May 2019

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

June 2019

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July 2019

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August 2019

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September 2019

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October 2019

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November 2019

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December 2019

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

If you have more than one pay cycle please **color** code and indicate below which color is for which payroll cycle.

CORPORATE PLANNING NETWORK

Date……..: _____

Plan Sponsor……: _____

Plan Representative…..…..: _____

Plan Year……..: _____

Re……..: 2018 Key Employee Designations – Section 125 Cafeteria Plan

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In order to apply the nondiscrimination rules of Section 125, it is important to know who the highly compensated and key employees are, in favor of whom discrimination is prohibited. Under the 25% concentration test, no more than 25 percent of the aggregate of the statutory non-taxable benefits provided to all employees under all the plans may be provided to key employees.

The definition of a Key Employee was amended by the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) effective for years beginning after December 31, 2001.

Key Employees: List all employees who, at any time **during the plan year**, fit into one or more of the following categories.

1. Officers with annual compensation greater than $175,000:

_____ _____ _____

_____ _____ _____

_____ _____ _____

2. Employees with more than 5% ownership:

_____ _____ _____

_____ _____ _____

_____ _____ _____

3. Employees with more than 1% ownership and annual compensation greater than $175,000:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Failure to comply with the Section 125 discrimination test will result in the key employees being taxed on all elected benefits.

CORPORATE PLANNING NETWORK

Plan Sponsor……: _____ Date: _____

Plan Representative…….....: _____

Re……..: 2018 Highly Compensated Employees Designation
Section 125 Cafeteria Plan – Dependent Care Assistance Plan

The Average Benefits Test states that the average benefits provided to employees who are not highly compensated under all parts of the employer must be at least 55 percent of the average benefits provided to highly compensated employees under all plans of the employer.

1. List all employees with more than 5% ownership during the prior or current plan year:

_____ _____ _____
_____ _____ _____
_____ _____ _____

2. List all employees who are a spouse or dependent of any individuals listed in 1 above:

_____ _____ _____
_____ _____ _____
_____ _____ _____

3. List all employees earning more than $120,000 in the prior plan year*:

_____ _____ _____
_____ _____ _____
_____ _____ _____

*An employer may elect to treat as highly compensated under the $120,000 compensation test only those employees who are also in the top-paid 20% group. Some employees can be excluded when determining the top paid group. These include employees who:

1. Have not completed six months of service
2. Normally work less than 17 ½ hours per week.
3. Normally work not more than six months per year.
4. Are union members.
5. Are non-resident aliens.
6. Are under age 21.