



Flex Plans Employer Application

Section 1: Requested Flex Plans (Please check all that apply.)

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|--|---|
| <input type="checkbox"/> Cafeteria Plan Includes FSA, POP and Non-Discrimination Testing | <input type="checkbox"/> COBRA |
| <input type="checkbox"/> Flexible Spending Account (FSA) Only includes healthcare and dependent care | <input type="checkbox"/> Health Reimbursement Arrangement (HRA) |
| <input type="checkbox"/> Premium Only Plan (POP) Requires a \$250 one-time fee with application* | <input type="checkbox"/> Medical Reimbursement Plan (MRP) |
| | <input type="checkbox"/> Transit Reimbursement Account (TRA) |

Section 2: Broker Information (If applicable, please complete in full.)

Brokerage Name: _____
 Broker Name: _____
 Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone: _____ Email Address: _____

Section 3: Employer Information (Please complete in full.)

Company Name: _____
(Enter company name exactly as it appears on the most recent tax documents.)
 Federal Employer ID No: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone: _____ Fax: _____

The Employer/Organization entity is operating pursuant to the laws of the State of: _____

Primary Employer Contact Person: _____
 Title: _____
 Telephone: _____ Email Address: _____

Section 4: Organization Type (Please select only one.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Government Agency | <input type="checkbox"/> Sole Proprietorship |
| <input type="checkbox"/> Professional Corporation | <input type="checkbox"/> Sub-chapter S-Corporation | <input type="checkbox"/> LLC (Limited Liability Company) |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Professional Association | <input type="checkbox"/> Other: _____ |

SIC Code of Industry: _____

For Cafeteria Plans, FSA, POP, HRA and MRP: Only employees can participate in this plan. Sole Proprietors, Partners in a Partnership, more than 2% shareholders of a Sub-chapter S-Corporation (including their spouses, children, grandchildren and parents of employees of the S-Corporation) Outside Directors, Limited Partners and Partners/Owners of an LLC cannot participate.

Section 5: Additional Information (Please complete in full.)

Requested Effective Date: _____ Number of Eligible Employees: _____
 Does this employer currently have an in-force plan? Yes No
 Is this employer being transferred (mid-year) from another Administrator? Yes No

To Submit the Flex Plans Employer Application:

For faster processing, you can **email or fax** the completed application to:
 E: fpsales@flexiblebenefit.com or F: 847-332-0320

Or mail completed application to:
Flexible Benefit Service Corporation 10275 W. Higgins Road, Suite 500 Rosemont, IL 60018

*POP Employer Application will need to be submitted along with a check for \$250 made payable to Flexible Benefit Service Corporation.