

FlexMagic Consulting, Inc. Premium-Only-Plan Implementation Questionnaire

Legal Company Name:	Dba (if any):	Today's Date:
(175) Corp Structure: <input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Non-Profit <input type="checkbox"/> Government <input type="checkbox"/> Sole Proprietor	Are You Part of a Controlled Group (50% or more common ownership with another company)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(201) Plan Coordinator: (completes day to day operations of plan)		(140) Birthday:
(202) Plan Administrator: (signs contracts and makes final decisions regarding the Plan)		(140) Birthday:
(203) Plan Year Start Date:	<input type="checkbox"/> 12-Month Plan Yr <input type="checkbox"/> Short Plan Yr	(211) 1 st Plan Yr. Effective Date:
(204) Plan Year End Date:	<input type="checkbox"/> New Flexible Benefit Plan <input type="checkbox"/> Restated / Amended Flex Plan	(210) Plan Number: 5__ __
(205) Open Enrollment Start Date:	(206) Open Enrollment End Date:	(207) Final Deadline Date (verification):
(212) EIN #:	(213) State of Incorporation:	(216) Date of Incorporation:
(217) Nature of Business:		(218) Min Age for Eligibility:
(219) # Work hours per week for eligibility:	(220) Entry Date: <input type="checkbox"/> 1 st Day of Month <input type="checkbox"/> 1 st Day Next Plan Year <input type="checkbox"/> Date of Hire	(221) Eligibility Requirements: <input type="checkbox"/> After ___ Days of Service <input type="checkbox"/> After ___ Months of Service <input type="checkbox"/> Date of Hire
Insurance Premiums to be included:	<input type="checkbox"/> (222) Health Insurance Premiums <input type="checkbox"/> Supplemental Health	(223) Carrier: Group #: Carrier: Group #:
	<input type="checkbox"/> (224) Dental Insurance Premiums	(225) Carrier: Group #:
	<input type="checkbox"/> (226) Vision Insurance Premiums	(227) Carrier: Group #:
	<input type="checkbox"/> (248) Group Term Life <input type="checkbox"/> Pre-Tax <input type="checkbox"/> After-Tax	(250) Carrier: Group #:
	<input type="checkbox"/> (250) Disability <input type="checkbox"/> Pre-Tax <input type="checkbox"/> After-Tax	(251) Carrier: Group #:
** Premium maximum equals the combined employee share of all eligible premiums (Example: health premium \$500 & dental \$75 = \$575 per month premium x 12 months = \$6,900 per year. Maximum is \$6,900 per year – we round it up by 10% to \$7,500.)	** (228) Pre-Tax Insurance Premium 12-month Maximum \$	(240) Maximum Salary Reduction / Cash Election \$ (same value as #228)
	(241) Number of Pay Dates 12-month Plan Year	(242) First Salary Adjustment Date

(252) Benefit Allowance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Premium Reimbursement Account: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Benefit Allowance Language Examples: (Select A, B, or C)	A	Benefit Dollars must first be used toward our Group Health Insurance Premiums unless proof of coverage under another group plan is provided. Benefit Dollars can then be used toward, any other company-sponsored insurance plan, or contributed to the 401(k) Plan. Benefit Dollars are prorated for new hires during the plan year. <input type="checkbox"/> 403(B) Plan <input type="checkbox"/> SIMPLE Plan <input type="checkbox"/> 457 Plan <input type="checkbox"/> Other	
	B	Benefit Dollars must first be used toward our Group Health Insurance Premiums unless proof of coverage under another group plan is provided. Benefit Dollars can then be used toward, any other company-sponsored insurance plan, 401(k) Plan or taken as taxable cash. Benefit Dollars are prorated for new hires during the plan year. <input type="checkbox"/> 403(B) Plan <input type="checkbox"/> SIMPLE Plan <input type="checkbox"/> 457 Plan <input type="checkbox"/> Other	
	C	Benefit Dollars can be used toward any company-sponsored insurance plan, 401(k) Plan or taken as taxable cash. Benefit Dollars are prorated for new hires during the plan year. <input type="checkbox"/> 403(B) Plan <input type="checkbox"/> SIMPLE Plan <input type="checkbox"/> 457 Plan <input type="checkbox"/> Other	

Client Company President:			
Client CPA:	Contact Name		
	Firm Name		
	Address		
	Phone	Fax	
	E-mail		
Retirement Plan Advisor:	Contact Name		
	Firm Name		
	Address		
	Phone	Fax	
	E-mail		
Insurance Broker:	Contact Name		
	Firm Name		
	Address		
	Phone	Fax	
	E-mail		
FlexMagic Internal Use:	Assigned Client ID #		Initial Check Received Date:
			Check # Amount \$
Questionnaire Completed by: _____			
Date: _____ Phone: _____			
Comments: _____			