



Pre-Qualifying Checklist

For review and evaluation of your current benefit program complete the following information. We can then determine if the implementation of a Flexible Benefit Plan would be beneficial to your company. Return this form to FlexMagic Consulting, Inc. Please complete all information.

Return this form to: _____

Corporate Office: Fax # (303) 649-1925 Questions Call: (303) 649-1922 or 1-800-888-9084
Western Branch Office: Fax # (970) 384-1901 Questions Call: (970)384-1900 or 1-800-613-4021

Name of Employer _____
Contact Person _____
Address _____
Phone # _____ Fax # _____

Why are you interested in looking at a Flexible Benefit Plan? (check all that apply)

- Reducing employee payroll costs
- Expanding benefit options
- Allowing employee-paid group insurance premiums be tax free
- Allowing employees to pay up to \$5,000 in child/dependant care tax free
- Allowing out-of-pocket medical, dental and vision expenses to be tax free
- High Deductible Health Plan and Health Savings Account Interest
- Other _____
- Controlling the cost of benefits
- Equalizing the value of benefits for all employees

No. of employees _____ No. of pay periods per calendar year _____
Fewer than 5 benefit-eligible employees often causes discrimination testing problems

% Single employees (no children) _____ % % Married employees or single w/ children _____ %

Structure of Company

- Sole Proprietorship
- Partnership
- S-Corporation
- Limited Liability Corporation
- Non-Profit Organization
- Government Entity
- C-Corporation
- Other _____

General Business Questions

No. of business locations _____
Corporate office location _____
Payroll is done at what location:
 One location
 Several locations
Number of locations _____
 Payroll Service
Who _____

Sole-Proprietorship, Partners, S-Corporations and LLC, 2% or more owners can not participate in the plan. Employees can participate based on eligibility requirements established by the employer.

Are there other companies with shared ownership (50% or more) by the same owner as this company?
 Yes No
If yes, explain _____

Discrimination Testing Requirements:

Discrimination tests are required when you offer a Flexible Benefit Plan. To determine if there are possible testing problems please answer the following questions:

Estimated number of Key employees: _____

A key employee is an owner or an administrative executive (officer) earning over \$ _____ (a specified dollar amount) per year. Count the spouse if he/she also works for the company. Exclude sole proprietors, partners, 2% or more S-Corporation and LLC owners from this count. (Ask for this year's exact dollar value, 2008 key employee income = \$105,000 or more; owners are generally 5% or more stock holders)

Estimated number of Highly-Compensated employees: _____

A highly compensated employee is anyone earning over \$ _____ (a specified dollar amount) who is also in the top 20% highest paid of all employees. Exclude sole proprietors, partners, 2% or more S-Corporation and LLC owners from this count. (Ask for this year's exact dollar value- for 2008 HC is based on anyone who earned \$150,000 or more in 2007 – a look-back year)

Does the eligible (5% or more) owner or spouse have a child/dependent care need?

YES NO

If yes, approximately how many dollars will be paid per year? \$ _____

How many Highly-Compensated employees have a child/dependent care need? _____

Approximately how many Highly Compensated C/D Care dollars will be paid per year? _____

HEALTH RELATED INSURANCE QUESTIONS:

Do you offer group health insurance for your employees? YES NO

Do you offer group dental insurance for your employees? YES NO

Do you offer group vision insurance for your employees? YES NO

If yes, what portion of the premium (if any) does the employer pay what portion does the employee pay? Explain: _____

How many employees contribute to the company insurance premiums each month? _____

How many employee dollars are contributed toward these premiums each month? _____

What are eligibility requirements for insurance? _____
(Waiting period) (Hours per week)

When do your insurance plans renew? _____

How is your health insurance plan structured? PPO HMO HDHP
 POS Combination w HSA

How is your dental insurance structured? PPO Discount Program
 Indemnity Combination

How is your vision structured? Explain: _____

Do you offer an HRA Plan? Yes No Interested

Do you offer Disability Insurance?

- Yes No

If yes, what type of plan is offered?

- Short Term Disability Insurance
 Long Term Disability Insurance
 Both

Who pays for the Long Term Disability Plan?

- Employer
 Employee
 Combination

Explain: _____

Do you offer Long Term Care Insurance?

- Yes No

If yes, what type of plan is offered?

- Employer-paid for all
 Employer-paid for a select group
 Voluntary purchase only
 Combination-employer-paid & voluntary purchase

Do you offer Pre-Paid Legal Services?

- Yes No

- Employer-paid
 Voluntary purchase only

MEDICAL/DENTAL & VISION EXPENSES:

What type of expenses for Medical, Dental and/or Vision are not covered by company insurance?
(Copays, Deductibles, etc.)

CHILD/DEPENDANT CARE EXPENSES:

Do you have employees who have child or dependant care needs? Yes No

If yes, how many do you estimate have a need? _____

Estimate child/dependant care dollars paid each year \$ _____

Do you offer Group Term Life Insurance?

- Yes No

If yes, how is life insurance offered? (check all that apply)

- Part of health plan
 Employer sponsored independent of health plan

Who pays for the group term life insurance?

- Employer
 Employee
 Combination

Explain: _____

Does the company offer a Retirement Plan?

- Yes No

If yes, what type of plan? _____

Does the employer make contributions to the retirement plan? Yes No

If yes, how is the contribution factored?

Do you offer Supplemental Health Insurance?

- Yes No

List supplemental products currently available:

List programs you are interested in learning about: _____



Most employers are pleased to offer a Flexible Benefit Plan for their employees. A plan can help the company address many benefit issues:

- ✓ Provides significant reductions in payroll taxes for employer and employee.
- ✓ Offers more employee choice and personal responsibility.
- ✓ Adds cost-control features through better benefit management.
- ✓ Increases employee appreciation and improves morale which reduces employee turnover.
- ✓ Improves the ability to compete in recruiting top quality employees.

Most FlexMagic Consulting, Inc. clients realize a 200% to 500% return on their first-year investment in a Flexible Benefit Plan.

Can owners participate in the plan?



Sole proprietors, partners and 2% or more S-Corporation and LLC and LLP owners are not eligible to participate in the plan. However, non-owner employees of these companies can participate.

Owners of C-Corporations are eligible to participate, but are subject to certain discrimination tests.

What discrimination testing must be completed for a FlexMagic® plan?

Owners, Key & Highly Compensated employees cannot have a disproportionate share of the before-tax benefits within the plan. The plan design cannot favor these individuals. When the child/dependant care benefit is offered, additional tests apply.

Is there any reporting required when you offer a plan?

At the end of each plan year a 5500 Form is filed with the IRS, if applicable (Note: currently not required for most plans). A Plan Document and Summary Plan Description is also required. Employees are given calendar year and plan year-end statements showing the before-tax dollars paid to them. The tax-free child/dependant care dollars are reported on the W-2 Form.

What services are provided by FlexMagic Consulting, Inc.?

Visit our website at www.flexmagic.com



I. ***FlexMagic®***
Flexible Benefit
Plan Consulting
Services

II. Health Reimbursement Arrangement (HRA)
Consulting

III. Third Party Administration for Flexible
Spending Accounts & HRAs with Debit
Cards (Optional)

IV. Health Savings Account Flex Plan
Integration

We also specialize in:

- ✓ Long Term Care Insurance
- ✓ Pre-Paid Legal Services
- ✓ Voluntary Supplemental Insurance

Pre-Qualifying Checklist Instructions



Complete the Checklist and return it to FlexMagic Consulting, Inc.
Estimates of data requested are acceptable.

OR

Complete the checklist and have employees complete the Flexible Benefit Plan Employee Survey (backside of this page). This method will provide more useful data, but is not required.

If you complete the Employee Survey information, return the Employee Survey information (below) along with the Checklist.

Employee Survey Summary

Company Name: _____

Number of Benefit Eligible Employees _____

Number of Surveys returned _____

Child/Dependant Care:

Total # Employees responding _____

Total annual dollar value of employees responding \$ _____

(minus those already using tax-free child/dependant care)

Medical, Dental & Vision Expenses:

Total # Employees responding _____

Total annual dollar value of employees responding _____

(minus those already using tax-free medical expenses)

Health Related Insurance Premiums:

Total # employees who pay premiums:

Group Health _____ Individual Health _____

Total annual dollar value of employee-paid premiums:

Group Health \$ _____ Individual Health \$ _____

(exclude premiums to any other group plan, except your company's plan)

Note: Premiums for individual health plans are generally not eligible within a Flexible Benefit Plan.

Flexible Benefit Plan Employee Survey

We are currently reviewing our benefit package and would appreciate this survey being completed and returned to _____ by _____

Thank you for your response!

I anticipate paying the following expenses during the next 12-month period:

Child/Dependant Care:

I pay child care expenses for children under the age of thirteen or for an older dependant who has physical or mental disability requiring supervision while I work.

Yes No

If yes,

Total Child/Dependant Care expenses expected during the next 12 months \$ _____

I am currently paying these expenses tax-free through a Flexible Benefit Plan.

Yes No

Medical/Dental Expenses:

I pay out-of-pocket Medical, Dental and Vision expenses for myself and/or spouse, family. These include co-payments, deductibles, glasses, braces, preventive care, etc.

Yes No

If yes,

Total Health Care expenses expected during the next 12 months \$ _____

I am currently paying these expenses tax-free through a Flexible Benefit Plan.

Yes No

Health Related Insurance Premiums:

I pay a portion of my health related (health, dental, vision) insurance premiums.

Yes No

Check One:

My Company Plan

My Individual Plan

Total premium that will be paid by me over the next 12 months
(do not include the company-paid portion of the premium) \$ _____

FlexMagic is a registered trademark of FlexMagic Consulting, Inc.

*Corporate Office: 6450 S Quebec St. Suite 5-28, Centennial CO 80111 * 303-649-1922 / 800-888-9084 * www.flexmagic.com
Western Branch Office: PO Box 176 (817 Colorado Ave #106) Glenwood Springs, CO 81602 * 970-384-1900 / 800-613-4021*