HRC TOTAL SOLUTIONS
HR•Payroll•FSA•HRA•HSA•Commuter•COBRA

SECTION 125 EMPLOYER APPLICATION (POP, FSA AND DCA)

I. EMPLOYER INFORMATION

Employer Name:		Tax ID #:	
Business Structure:		State Organized In:	
Mailing Address:	City:	State:	Zip:
Street Address (if different):	City:	State:	Zip:
Telephone:	Fax:		
Are there any Affiliated Companies that are also eligible for this benefit? ☐ Yes ☐ No			

II. IMPORTANT CONTACT INFORMATION

Contact Name	Phone #	Email	Type of Contact (check all that apply)
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing
			☐ Primary ☐ Secondary ☐ Enrollment ☐ Billing
Broker Agency:			Phone #:
Broker Contact Name	Phone #	Email	Type of Contact (check all that apply)
			☐ Primary ☐ Secondary ☐ Account Manager ☐ Producer
			☐ Primary ☐ Secondary ☐ Account Manager ☐ Producer

III. PLAN ELIGIBILITY

Please enter the requirements in order for an employee to be eligible for these plans below, as well as some information on how many employees are employed, and eligible.

Plan	Hours Worked per week:	Length of employment:
Premium Offset Plan (Conversion Plan) (POP)		
Health Reimbursement Account (FSA)		
Dependent Care Reimbursement Account (DCA)		
Total # of employees:	Total # eligible:	
Will you require your reporting to be listed by division? ☐ Yes ☐ No *If **yes**, list the name for each division:* _____		

HRC TOTAL SOLUTIONS
HR•Payroll•FSA•HRA•HSA•Commuter•COBRA

IV. GENERAL ADMINISTRATION QUESTIONS

Health FSA's are COBRA Eligible Accounts per Federal COBRA Rules.

Who handles the COBRA administration when an employee terminates? _____

V. PLAN DESIGN

Please fully complete the below section to ensure accuracy of plan set up.

1. Original Effective Date of Section 125 Cafeteria Plan:
2. Plan Year:
3. Will this be a short plan year? ☐Yes ☐No
3A. If 'Yes' indicate Next plan year:
3B. Maximum for Short Year: $_____ Maximum for full Year: $_____ *Maximum must be prorated for short plan year based on IRS maximum

Premium offset Plan: ☐Yes ☐No
Check those which apply: ☐ Medical ☐ Dental ☐ Vision ☐ Other: _____

Health Care Flexible Spending Account: ☐Yes ☐No	
Maximum: ☐ IRS Maximum ☐ Custom: $_____	Employer Contribution: $_____
☐ Rollover Allowed; Amount: $_____ **OR**	☐ 2 ½ Month Grace Period Allowed
Plan includes a 90-day runout period by default.	

Limited Flexible Spending Account: ☐Yes ☐No	
Maximum: ☐ IRS Maximum ☐ Custom: $_____	Employer Contribution: $_____
☐ Rollover Allowed; Amount: $_____ **OR**	☐ 2 ½ Month Grace Period Allowed
Plan includes a 90-day runout period by default.	

Dependent Care Flexible Spending Account: ☐Yes ☐No	
Maximum: ☐ IRS Maximum ☐ Custom: $_____	Employer Contribution: $_____
☐ 2 ½ Month Grace Period Allowed	
Plan includes a 90-day runout period by default.	

HRC TOTAL SOLUTIONS
HR•Payroll•FSA•HRA•HSA•Commuter•COBRA

VI. PAYROLL INFORMATION

Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly	
1st Payroll Deduction in new plan year: _____	Number of Payroll deductions this year: _____

VII. ENROLLMENT METHOD

☐ Online Enrollment through HRCTS System ☐ Excel Spreadsheet ☐ Paper Enrollment Forms
☐ Internal Online Enrollment System (with direct feed to our SFTP; setup required)

VIII. FEES AND SIGNATURES

Please review this application carefully, then please read and sign that you agree to the below fees.

Setup Fee: $	Annual Renewal Fee: $	
PEPM Fee: $	Monthly Minimum Billing: $	
Combined Account Fees: $		
There will be a funding deposit required for this account administration. The amount is determined after initial enrollment and is the equivalent of two months' deductions or $2,000 whichever is greater.		
Fee Comments:		
Authorized Signer's Name (print)	Title	Date
Signature:		