WageWorks

Cafeteria Plan Document Preparation Services Form

To accurately create Plan Documents and Summary Plan Descriptions (SPDs), please complete every question. Please submit request for documents through Salesforce, and attach this form.

1. Legal name of the employer: _____ Company Code _____
2. Address of the employer: (Street) _____, (Suite)_____,
   City, State, Zip: _____
3. Employer's principal office location: _____ (State, Commonwealth or District)
4. Phone number of the employer: _____
5. Business entity type: ____ C-Corp, ____ Sole Proprietorship, ____ Partnership, ____ Not-for-Profit
   ____ S-Corp, ____ LLC, ____ Government or Church
6. Employer's Federal Tax ID number: _____
7. Plan year (month, day, and year): Start _____ End _____
8. Employer subject to COBRA? ____ Yes ____ No (default based on number of employees in account)
9. Employer subject to FMLA? ____ Yes ____ No (default based on number of employees in account)
10. Will this be included in a "wrap" plan? (Is this FSA incorporated into a "wrap" document?) ____ Yes ____ No
11. Plan effective date:
    a. If first year is a short plan year, it begins/ends (mm/dd/yy): _____to_____
    b. New plan effective date: _____
    c. Amendment and restatement of a previously established cafeteria plan:
        i. Amendment and restatement effective date: _____
        ii. Effective date of original plan: _____
        iii. Formal name of original plan: _____
        iv. Plan number of original plan (consult last Form 5500 filing) _____
12. Eligible employees:
    a. ____ All employees who satisfy eligibility requirements
    b. ____ Salaried employees only
    c. ____ Hourly employees only
    d. ____ All employees except:
        i. ____ Commissioned employees
        ii. ____ Union employees
        iii. ____ Leased employees
        iv. ____ Part-time employees, expected to work less than _____ hours per week
        v. ____ Nonresident aliens
        vi. ____ Employees not eligible under the employer's group medical plan
        vii. ____ Those who have not completed _____ hours of service (default is 1,000 hours)
        viii. ____ Those who have not attained age _____ (cannot exceed 21)

Please Note: Plan documents will be prepared based upon the content provided within this document. Please ensure that the information provided is consistent with the plan specific provisions. Plan documents should be reviewed and approved by the employer's legal counsel prior to adoption (signed and implemented). Any changes suggested during that review are the responsibility of the employer.

13. Conditions for Eligibility:
    a. ____ Same as employer's group medical plan
    b. ____ For first plan year only, anyone employed on the effective date (thereafter choose from (c) ii – iv below)
    c. ____ For all years, eligibility is as follows
        i. Date of hire (no service required)
        ii. _____ years after date of hire
        iii. _____ months after date of hire
        iv. _____ days after date of hire

14. Plan Entry date:
    a. ____ First day of the pay period next following date requirements were met
    b. ____ Date conditions for eligibility are met
    c. ____ Dual entry (1st day of plan year & 6 months later)
    d. ____ First day of plan year following date requirements were met
    e. ____ First day of month following date requirements were met
    f. ____ Same as employer's group medical plan

15. Contribution Types
    a. ____ Salary reduction contributions only
    b. ____ Employer contributions only
    c. ____ Salary reductions and employer contributions

16. Employer contributions method:
    a. ____ of compensation per participant
    b. $_____ per participant
    c. ____ Discretionary

17. And timing of the contributions shall be:
    a. ____ At the beginning of the plan year
    b. ____ Pro rata each pay period

18. Employer contributions are convertible to cash:
    a. ____ Yes
    b. ____ No

19. Employer contributions are to be made to:
    a. ____ All accounts
    b. ____ Health FSA
    c. ____ Dependent Care FSA
    d. ____ HSA

20. Benefit options (check ALL that apply):

    a. ____ Healthcare FSA

i. HC annual limit. ($2,550 max per 12-month plan year. (If short plan year the $2,550 will be prorated. See 20a.iii.) $ _____.
ii. HC minimum annual limit. $ _____. (Not supported by WinFlexOne)
iii. HC short Plan year maximum limit. $ _____.
iv. HC mid-year entry maximum contribution. $ _____.
v. HC run out Days after plan year end or end of Grace Period. _____ Days (Suggest maximum of 60)
vi. HC run out for terminated Employees. _____ Days (Suggest maximum of 30 days.)
vii. Are employer-provided debit cards used for expenses through HC FSAs? ____ Yes ____ No

b. ____ Dependent Care FSA
i. DC annual limit ($5,000 max per 12-month plan/calendar year.) $ _____.
ii. DC minimum annual limit. $ _____. (Not supported by WinFlexOne)
iii. DC short plan year maximum limit. $ _____.
iv. DC mid-year entry maximum contribution. $ _____.
v. DC Run out Days after plan year end or end of grace period. _____ Days (Suggest maximum of 60)
vi. DC run out for terminated employees. _____ Days (Suggest leave blank. Allows employee to incur expenses through the end of the plan year and turn in claims through the end-of-year run out)
vii. Are employer-provided debit cards used for expenses through DC FSAs?
____ Yes ____ No (Not supported by v5)

c. ____ Adoption Assistance (AA) FSA
i. AA annual limit $13,460 (2016) max per 12-month plan/calendar year (or current year IRS limit) $ _____.
ii. AA minimum annual limit. $ _____. (Not supported by WinFlexOne)
iii. AA short Plan year maximum limit. $ _____.
iv. AA mid-year entry maximum contribution. $ _____.
v. AA run out days after plan year end or end of grace period. _____ Days (Suggest maximum of 60)
vi. DC run out for terminated employees. _____ Days (Suggest maximum of 30 days.)

d. ____ Premium Payment Plan (Allows employees to pay eligible insurance premiums on a pre-tax basis
i. Premium Payment elected for: ____ Individual & dependent ____ Dependent health insurance only (Suggest for "Individual and dependent")
1. ____ Accidental Death and Dismemberment insurance
2. ____ Cancer insurance
3. ____ Dental insurance
4. ____ Disability insurance (uncommon – pre-taxing this benefit would make any disability benefits received taxable)
5. ____ Group-term life insurance
6. ____ Prescription Drug Coverage
7. ____ Vision insurance

21. Is the employer's group health insurance self-insured? ____ Yes ____ No

22. Auto Enrollment for insured benefits? ____ Yes ____ No (Suggest "Yes")

23. Participants who fail to sign new election form to have same elections as prior year only for insurance benefits?
    ____ Yes ____ No (Suggest "Yes") (If "No" is selected, participant is considered to have not elected for the upcoming plan year)

24. Employee Change in Status Allowed?
    ____ Yes ____ No (Suggest "Yes" in all instances.)
    All change in status reasons, including new provisions for employee change due to reduction in hours or enrollment in Exchange (Marketplace), are included in the plan document.

25. Healthcare FSA carryover annual limit $ _____ ($500 maximum) Leave blank if N/A
    Note that the Grace Period cannot be offered for Healthcare FSA if carryover is selected.

26. "Grace Period" (2 ½ month extended period of coverage to use prior year contributions) allowed?
    ____ Yes ____ No If yes, it applies to: ____ Health FSA ____ DC FSA ____ Adoption Assistance FSA

27. Health Savings Account (HSA) provided by the Employer? ____ Yes ____ No

28. To accommodate HSAs, a limited-purpose Health FSA will be limited to the following types of medical expenses:
    ____ NA

    ____ Dental expenses

    ____ Vision expenses

29. Employer subject to HIPAA? ____ Yes ____ No (always assumed "Yes")

30. Add the "Heart Act" (Qualified Reservist Distribution (QRD provisions for HC FSA. For uniformed services members deployed to active duty))? ____ Yes ____ No If yes, then complete the following:
    a. Disbursement amount determined at (either amount determined minus reimbursements paid):
       ____ Beginning of year FSA amount (FSA annual limit)
       ____ Amount contributed up to point of request **(most common plan choice)**
    b. Number of disbursements allowed? ____ (Suggest 2 disbursements)
    c. Claims submitted after QRD
       ____ shall be paid on submission as any other claim **(most common plan choice)**
       ____ shall not be paid
    d. Eligible claims for ____ participant and all dependents or only ____participant claims.

31. Legal Name(s) of Affiliated Company(ies), Address, Phone Number and Federal ID Number. (Attach to this request)

32. Additional comments:
    _____