BASIC FLEX

MDA - Chris Eckert

(269) 254-6228

Note:
S-Corp owner- with 2% or more stock and family members cannot participate in plan.

C-Corp- subject to non discrimination testing.

LLC, LLP, Partnership, Sole Proprietorship- owners cannot participate in the plan.

PC, PLC, PLLC- depends on how you file your taxes
   C-Corp-
   Yes, please see above
   S-Corp-
   No, please see above

*PLEASE NOTE:
- For employer groups with 20 or more employees, cash-in-lieu may not be offered to active employees eligible for or covered by Medicare.
- The Affordable Care Act (ACA) requires a qualified group health plan in order to offer a POP, FSA or HRA

Please type or print all information on both pages

ADMINISTRATION INFORMATION Legal

Company Name:_____

  DBA/AKA: _____

Physical Address:_____

City, State, Zip: _____

Business Structure (Required): ☐ Sole Proprietor ☐ Government ☐ Partnership
☐ Non-Profit ☐ C Corp ☐ S Corp ☐ PLLC ☐ PLC ☐ LLC ☐ PC

Industry Type: _____

Flex contact person:_____

Title: _____ Email:_____

Phone: _____ Ext: _____ Fax: _____

Legal Rep (owner or officer):_____

Total Number of employees: _____ Total Number of insured employees: _____

Plan year will be (based on 12 month period): _____ to _____

Effective Date with BASIC: _____

OTHER PLANS

1) Do you have a group health plan? ☐ Yes ☐ No

2) Do you have an existing Section 125 Plan (Flex Plan)?
   ☐ Yes   ☐ No
   If yes, original effective date of plan is (required): _____ Plan Number: _____

3) Do you have an existing Section 105 (HRA) Plan?
   ☐ Yes   ☐ No   If yes, plan number is: _____

4) Is your company required by law to provide COBRA continuation Coverage?
   COBRA requirement – 20 or more FTE employees for 50% of previous calendar year
   ☐ Yes   ☐ No

5) Is your company required by law to provide FMLA (Family Medical Leave Act) Continuation?
   FMLA requirement – 50 or more employees within a 75 mile radius
   ☐ Yes   ☐ No

PREMIUMS PRE-TAX (check all that apply)

☐ Health Insurance   ☐ Short Term Disability   ☐ HSA Contributions

☐ Dental   ☐ Long Term Disability
☐ Group Term Life (max. $50,000)   ☐ Other Premium type Programs (describe)   ☐ Employer ☐ Employee
☐ *Cash Option plan for: _____

REFFERAL SOURCE (how did you hear about BASIC)

Referral Company/Agency: _____

Contact Name & Email:: _____

Revised 8.9.16

BASIC FLEX POP

BASIC Flex POP is a Premium Only Plan, POP for short. The POP plan was established by Section 125 of the Internal Revenue Code. It allows you to pay for certain insurance benefits before taxes, which saves you money. The taxes you save are returned to you as increased take home pay. You may use BASIC Flex POP on employer-sponsored benefits which you pay a share of the premium cost. These may include health insurance, supplemental health, vision, dental, prescription insurance, the first $50,000 of group term life insurance (on the employee only), AD&D, short and long term disability, and Health Savings Accounts (HSAs).

Without BASIC Flex POP		With BASIC Flex POP	
Gross Taxable Wage	$400.00	Gross Taxable Wage	$400.00
Federal, FICA & State Tax	**-71.00**	Insurance premium co-pay	-25.00
Insurance premium co-pay	-25.00	Taxable Wage	$375.00
Weekly Take Home Pay	$304.00	**Federal, FICA & State Tax**	**-62.00**
		Weekly Take Home Pay	$313.00
		Annual Tax Savings	**$468.00**

You may change your annual election if you have a qualified change in status, such as: marriage, birth, death, divorce, or adoption. Also, pre-tax contributions through this plan could reduce your future Social Security Benefits; however, studies show it is usually less than 1%. The amount is minimal compared to the tax savings you receive with BASIC Flex POP.

C U T   H E R E

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ENROLLMENT FORM FOR BASIC FLEX POP

Employer Name: _____

Participant Name: _____ SS #: _____-_____-_____

☐ Open Enrollment ☐ New Hire (Hire Date: ____/____/____) ☐ Key Employee (Officer or Owner) ☐ Change in Status

☐ **I elect to participate** (the amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer. This amount will be changed as necessary, if the premium changed by the insurance company changes.)

Check all that apply:
☐ Health Insurance ☐ Group Life Insurance ☐ Disability Insurance ☐ Dental Insurance
☐ Other(s)_____

☐ **I decline to participate**

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by sum of my premium contributions to the plan, such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year, unless there is a change in my status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and change of employment of spouse) which justifies the revocation or change. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

ADMINISTRATION INVOICE PAYMENT OPTIONS

Payment options for ONLY administrative fees/invoices (example: invoice 10-123456 or 30-12345):

Payment sent via Check:	
Name:	BASIC
Street:	PO Box 775339
City, State, Zip code	Chicago, IL 60677-5339
Include on Check Stub:	Invoice Number and Customer ID

Payment sent via Direct Deposit:	
Bank Name:	JOINT UPIC ACCOUNT (PNC Bank)
9-Digit Routing Number:	021052053
Account Number:	45698895
Authorized By:	Audra Fillar
Title:	Finance Analyst
Contact Phone:	269-488-6271
Remit Email Address:	AR@basiconline.com
Include on Email and Bank Deposit Memo:	Invoice Number and Customer ID

For ACH or Credit Card pay, please complete next page.

ADMINISTRATION INVOICE PAYMENT AUTHORIZATION FORM

*By completing this form, you are authorizing the BASIC family of companies including BASIC Pacific and BASIC NEO to obtain payment for **startup and ongoing** administration fees. Auto-pay will remain in effect until BASIC receives notification canceling it or updating us with a different payment form in writing.*

Return Form to Sales Support via Email or Fax:	
Email: Sales@basiconline.com	Fax: (269) 327-4996

COMPANY NAME: _____

ACH and Credit Card payments cannot be processed without a proper authorizing signature.	
Authorized By: (please print or type name)	
Title:	
Contact Phone:	
AUTHORIZED SIGNATURE:	DATE:

Auto-Pay via ACH Payment	
Please complete and sign this section to allow direct debit payment.	
Bank Name:	
9-Digit Routing Number:	
Account Number:	
Our Bank Code ID:	1382883561

Auto-Pay via Credit Card Payment				
Please complete and sign this section to allow credit card payment.				
Cardholder's Name:				
Type of Credit Card:	☐ Visa	☐ Master Card	☐ American Express	☐ Discover
Credit Card Number:				
Expiration Date:				
CSV:				
Billing Zip Code				

INITIAL PAYMENT AMOUNT: $ 295.00

SERVICE: Premium Only Plan (POP)