



Premium Only Plan (POP) Employer Application

Please mail completed form to:
 Health Equity Client Services
 15 West Scenic Pointe Drive, Suite 400
 Draper, UT 84020
 Phone: 866-382-3510

Instructions: Please complete this form and submit to HealthEquity with the plan set up fee of \$250. Please allow 30 days to process and return plan document to the employer. An employer signature on the POP is *required* before the plan can take effect.

Part 1: Company Information		
Company Name		
Address		
City	State	Zip
Federal Tax Identification Number:	State of Incorporation	ERISA Plan Number (if applicable)
Nature of Business:		
Employer Entity (check one):		
<input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Limited Liability <input type="checkbox"/> Government or church		
Business Principals		
CEO Name	CFO Name	
Primary Contact Information		
Plan Administrator Name	Title	
Phone	Fax	
E-mail		

Part 2: Plan Effective Dates		
Plan Name:		Plan No:
Plan Year Start Date: ____/____/____	Plan Year End Date: ____/____/____	Run Out Date: ____/____/____
Is this a short plan year? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify Plan Start Date: : ____/____/____ and End Date: ____/____/____		
Is this a restatement of a previously adopted plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Effective Date of Plan Restatement: ____/____/____		



Part 3: Plan Design (Please check benefits to be offered under the plan)

- Medical Coverage premiums
- Dental Coverage premiums
- Disability Coverage premiums
- Term Life Coverage premiums
- Flexible Spending Account (FSA)
- Health Reimbursement Arrangement (HRA)
- Health Savings Account (HSA) contributions
- Other Coverage Premiums

Part 4: Eligibility Requirements

1) The following employees are excluded from participating:

- No exclusions
- Hourly Employees
- Salaried Employees
- Part time employees expected to work less than ____ hours per week
- Employees under the age of: ____
- Union employees
- Non-resident aliens
- Other: _____

2) The service period employees must complete before being eligible to participate:

- Date of hire/Immediate
- Number of days after hire: ____
- Number of months after hire: ____

3) Once employees are eligible, they can begin participating in the plan:

- First day of pay period following the eligibility date.
- First day the month following the eligibility date.
- First day of quarter following eligibility date.
- First day of plan year following the eligibility date.
- Date employee becomes eligible



Part 5: Contributions

1) When may Participants **modify** elections regarding contributions:

- At any time permitted under IRS regs
- Pursuant to Plan Administrator procedures (Change in status; Judgement,decree or legal order; Enrollment in Medicare; FMLA)

2) Will Company contribute to plan:

- No
- Yes, at Company's sole discretion
- Yes, pursuant to a fixed method

If "Yes - pursuant a fixed method", describe how the contributions are determined: _____

3) If 2 is not "No", indicate whether the Plan permits Participants to elect cash in lieu of benefits:

- No
- Yes, with limitation
- Yes, without limitation

1. If 2 is not "No" and if 3 is "Yes - with limitation", describe any limitations: _____

Part 6: Plan Administrator

Designation of Plan Administrator: Plan Sponsor Committee Appointed by Plan Sponsor Other

If "Other", Name of Plan Administrator: _____

Type of Indemnification for the Plan Administrator: None Standard Custom

If "Custom", enter indemnification for the Plan Administrator: _____

Part 7: Other Provisions

Indicate whether the Plan is subject to COBRA: No Yes

If "Yes", indicate the contact name listed in the COBRA Notice: _____

If "Yes", indicate the contact address listed in the COBRA Notice: _____

If "Yes", indicate the contact phone listed in the COBRA Notice: _____

If "Yes", enter the number of days within which a Participant must notify the Plan Administrator of certain qualifying events such as divorce or legal separation or a dependent child's losing coverage: _____

Indicate whether the Plan is subject to FMLA: No Yes



Part 8: Authorized Signature

I hereby authorize HealthEquity to provide plan administration services based on the information in this Employer Application.

Authorized Signature: _____ Date: _____

Please Mail Completed Forms and \$250 Check To:

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Draper, UT 84020
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