

# Premium Only Plan Questionnaire



## Employer Information

Employer Company Name

Employer EIN

Employer Organization Type

Corporation, Limited Liability Company, Partnership, S Corporation, Sole Proprietorship, Non-Profit Organization, Estate, Professional Corporation, Governmental Entity or Church

Employer Organization State

## Employer Primary Contact Information

Contact Name (First & Last)

Address

Address

City

State

Zip

Phone Number

Email Address

## Affiliates (if applicable)

An affiliate generally means:

- Subsidiaries which are owned (at least 80% ownership) by the plan sponsor
- Other companies which are owned (at least 80% ownership) by a parent company which also owns 80% of the plan

## Document Information

Would you like to add a custom appendix item to the table of contents? (if unsure YES / NO choose no)

# POP Questionnaire

## Plan Information

Is this Plan new or a restatement?

New / Restatement

If this is a brand new plan for your company, please select "New." If you are amending and restating a previous plan, please select "Restatement"

Plan Year Start

mm/dd/yyyy

The Plan Year Start should be consistent with the plan year for all other group benefits if possible. Do not back date a plan year start.

Plan Year End

mm/dd/yyyy

The date on which this Plan Year ends - typically the end of the calendar year or the end of the 12th month after the Plan Year Start - with the exception of short plan years.

Original Effective Date  
(only if Restatement)

mm/dd/yyyy

Amended and Restated Date  
(only if Restatement)

mm/dd/yyyy

Short Plan Year

YES / NO

Renewal Year Start  
(only if short Plan year)

mm/dd/yyyy

State the date on which the Plan year that follows the short plan year will start.

Renewal Year End  
(only if short Plan year)

mm/dd/yyyy

State the date on which the Plan year that follows the short plan year will end.

# POP Questionnaire

## Plan Benefits

### Does your plan offer the following benefits on a pre-tax basis? ( YES / NO )

Group Medical Insurance	Individual Medical Insurance under an ICHRA
Group Dental Insurance	Long-Term Disability Insurance
Group Vision Insurance	Short-Term Disability Insurance
HSA Contributions	Accidental Death and Dismemberment Insurance
Group Term Life	Critical Illness Insurance
Cancer Insurance	Hospital Indemnity Insurance
Voluntary Benefits	Cash In Lieu of Benefits
Personal Sickness Indemnity	Intensive Care Insurance
Specified Health Event	Accident Insurance

## Elections and Plan Options

Employee Elections	Election Required First Year Only / Election Required Each Plan Year / No Election Required, May Opt-Out
Include Participant Election Forms	YES / NO
Allow Change of Status if employee Full-Time status drops below 30 hours?	YES / NO
Allow Change of Status if employee is eligible for a Special Enrollment or Annual Open Enrollment Period in a qualified Health Plan within a Marketplace?	YES / NO
Allow a Change in Status in the middle of the plan year if an employee's dependent is eligible for a Special Enrollment to enroll in a Qualified Health Plan within a state or federal Exchange?	YES / NO
Include FMLA Language?	YES / NO