



2601 Lac De Ville Boulevard
 Rochester, New York 14618
 Phone (585) 427-2010 Fax (585) 427-2293

**SECTION 125 PLAN PREMIUM CONVERSION ADOPTION AGREEMENT
 EMPLOYER INFORMATION FORM**

DATE: _____

CLIENT #: _____

EMPLOYER INFORMATION

Legal Name: _____
 DBA Name: _____
 Address: _____
 City/State/Zip Code: _____
 Contact Name: _____
 Title: _____

Federal ID #: _____
 Phone #: _____
 Fax #: _____
 Plan Effective Date: _____
 Plan Number: _____
 (Assigned by USA Payroll)

Definition of Key Employee:

- ❖ An officer of the company.
- ❖ A 5% or more share holder.
- ❖ A 1% or more share holder earning > \$150,000.
- ❖ A beneficiary of the mentioned above.

Definition of Highly Compensated Employee:

- ❖ An officer of the company.
- ❖ A 5% or more share holder.
- ❖ A beneficiary of the mentioned above.

Please list all of the Key and Highly Compensated Employees (HCE):

Employee Name:	Social Security Number:	Type of Employee (Check One)
		<input type="checkbox"/> Key <input type="checkbox"/> HCE
		<input type="checkbox"/> Key <input type="checkbox"/> HCE
		<input type="checkbox"/> Key <input type="checkbox"/> HCE
		<input type="checkbox"/> Key <input type="checkbox"/> HCE
		<input type="checkbox"/> Key <input type="checkbox"/> HCE

Benefits to be covered under the premium conversion provisions. Please attach summary plan descriptions for each applicable plan:

Benefit Type (Check all that apply):	Carrier:	Group Number:
<input type="checkbox"/> Health Insurance		
<input type="checkbox"/> High Deductible Plan		
<input type="checkbox"/> Health Savings Account (HSA)		
<input type="checkbox"/> Dental Insurance		
<input type="checkbox"/> Vision Insurance		
<input type="checkbox"/> Term Life Insurance		
<input type="checkbox"/> LTD (Long Term Disability)		
<input type="checkbox"/> Cancer Insurance		
<input type="checkbox"/> Dependent Care FSA through USA Payroll (Section 125 – FSA Affidavit of Dependent Care Costs Form(s) required)		

In adopting this Premium Conversion Plan for my employees under Section 125 of the Internal Revenue Code, I agree to abide by the terms, conditions, and provisions of the Section 125 Plan Document.

Employer's Authorized Signature: _____

Date: _____

Authorized Signature Title: _____

USA Payroll Representative Signature: _____

Date: _____