

Premium Only Plan Agreement



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ManleyPlan.com

EMPLOYER DATA

_____ Employer		_____ Tax ID number
_____ Address, city, state, ZIP		_____ Fiscal year end
_____ Payroll contact	_____ Phone number	_____ Fax number
_____ Payroll contact's e-mail address	_____ State where co. was formed	_____ Date co. was formed
_____ Insurance agent name		_____ Agent's address
_____ Manley Services Representative		_____ Group health insurance carrier

Type of legal entity (check one box)

- | | | | |
|--|---------------------------------------|---|-------------------------------|
| <input type="checkbox"/> Regular Corporation | <input type="checkbox"/> Nonprofit | <input type="checkbox"/> "S" Corporation* | <input type="checkbox"/> LLC* |
| <input type="checkbox"/> Municipality | <input type="checkbox"/> Partnership* | <input type="checkbox"/> Sole proprietorship* | <input type="checkbox"/> LLP* |

*Shareholders or owners of these types of business are not eligible to participate.

Control Status

If the employer is a member of a controlled group of companies or an affiliated service group of business entities, it may be required that all employees of the business entities within the group be treated as though they were employed by a single employer for the purposes of the plan.

- | | | |
|---|------------------------------|-----------------------------|
| Is the employer a member of a controlled group of companies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the employer a member of an affiliated service group? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Will any affiliated company or related business adopt the plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Plans Offered

- POP (Premium only) HSA POP (Premium for Health Savings Accounts)

Eligibility Requirements (check one)

- Normally work _____ hours per week
 Normally work _____ or more months during each calendar year
 Complete _____ or more months of continuous employment. (Should not be more than the eligibility period applicable to Employer's group health plan for full time employees.)

Do you have any excluded employees? Yes No

If yes, please specify (i.e., seasonal, temporary, contracted, etc.): _____

SERVICE AGREEMENT

Effective date of plan _____ Fees: First year \$200 or \$150 (PacificSource group); Renewal fee: \$150

The first year, the plan shall operate from (mm/dd/yy): _____ to (mm/dd/yy): _____

The second and subsequent years, the plan year shall begin on the first day of (Month): _____

Employer signature: _____ Date: _____

Title: _____

Please sign and return this form to the address above, and include a check for the first year's fees.