

American Benefit Services, LLC

Employer Application Form

FSA

HRA

HSA

POP

COBRA

Legal Name of Company Sponsoring Plan: _____

Business Entity Type: Sole Proprietorship Partnership C Corp.
 Not-for-profit Limited Liability Co. S Corp.
 Government Entity or Church

Principal Business Activity: _____ in the state of: _____

Federal Tax Id#: _____

Contact Person: _____ Title: _____

Street Address: _____

City: _____ State/Zip _____

Phone: _____

Fax: _____ Email: _____

This Plan will be:

A new plan effective as of _____

An amendment and restatement of a previously established plan.

this amendment/restatement will be effective as of _____

the effective date of the original plan _____

the original plan # was _____

Plan Year End: _____ Pay Frequency: _____

Benefits under this plan include:

Medical expenses \$ _____

Adult/Child daycare

Health insurance premiums

Dental insurance premiums

Vision insurance premiums

Accidental death

Group-term life insurance

Cancer insurance

Total Number of Employees: _____

Notes: _____
