CONEXIS
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POP Application

Please complete online using Microsoft Word® or print clearly. Return this Application, a signed Service Agreement, a completed Discrimination Data Collection Form and a check for the applicable implementation fees to CONEXIS, Attention: POP Sales, 721 S. Parker, Suite 300, Orange, CA 92868.

Section A – Employer Information. Please fill out completely.

Company Name	DBA (if applicable)

Address

City	State	Zip

Telephone Number	FAX Number	FEIN	SIC Code

Employer Entity (check one)

☐ Sole-proprietorship ☐ Partnership ☐ S-Corporation ☐ LLC ☐ Corporation (State of Incorporation: __) ☐ Other _____

Sole-proprietors, partners in a partnership, more-than-2%-owners in an S-Corporation (and their family members), and members of an LLC may not participate in a cafeteria plan.

Total Number of Employees	Number of Eligible Employees	Percentage of non-English Speaking Employees
		%

Plan Administrator Contact Name (all correspondence will be sent to this individual)	Title

Telephone Number	Fax Number	Email address
ext.		

Section B – General Plan Information (All information provided in this section will be used to create the Plan Document)

Plan Name (e.g. ABC Inc. Premium Only Plan, ABC Inc. Section 125 Plan, etc):

Will the first plan year of this plan be a short plan year (less than 12 months)?	If yes, short plan year start date:	Short plan year end date:
☐ Yes ☐ No		

Plan Year Start Date	Plan Year End Date

Original effective date of any Section 125 plan sponsored by company:	ERISA Plan Number (e.g. 501)	Number of days employee has to provide notice of a Change in Status Event:

Pre-tax premium deductions may be elected for (check all that apply):

☐ Health Insurance ☐ Dental Insurance ☐ Vision Insurance ☐ Group-Term Life ☐ Disability ☐ Other (specify) _____

Who is eligible to participate?	Eligibility Waiting Period:
☐ Full-time Employees ☐ Part-time Employees ☐ All Employees	☐ First of the Plan Year ☐ First of the Month following (number of):
Minimum hours worked required to be eligible: ______	☐ Days ☐ Months ☐ Other ______

Does this plan have any Additional Adopting Employers? (if yes, please copy this form and complete Section A for each Additional Adopting Employer)

☐ Yes ☐ No

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Section C – Broker Information				FOR CONEXIS USE ONLY
Broker Name		Broker of Record for Medical Plan? ☐ Yes ☐ No		Broker Code
Agency Name		Agency FEIN		
Address				
City		State	Zip	
Telephone Number ext.	FAX Number	Email Address		

Accepted and agreed to by an Authorized Company Representative – By signing this application, I certify that the information above is correct to the best of my knowledge.

Company representative's signature		Date
Form completed by:	Phone Number	Date form completed c

Please complete this form in its entirety. Incomplete forms will result in a delay in implementation and may lead to loss of desired effective date.