

# Premium Only Plan (POP) Employer Application

Mail completed form to:

**Address:** HealthEquity, Attn: Client Services  
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

**HealthEquity**<sup>®</sup>  
Building Health Savings™

The below terms will assist with any questions pertaining to certain fields within the POP Employer Application.

<b>Plan Administrator</b>
It is most common for the employer to be listed as the plan administrator as they are the owner of the plan. (This is not HealthEquity.)
<b>Affiliate</b>
An affiliate generally means: <ul style="list-style-type: none"><li>• Subsidiaries which are owned (at least 80% ownership) by the plan sponsor</li><li>• Other companies which are owned (at least 80% ownership) by a parent company which also owns 80% of the plan</li></ul>
<b>Plan Name</b>
A formal name of the ERISA Plan determined by the Plan Sponsor (ex: ABC Company HRA Plan)
<b>Plan Number</b>
Plan number is used in 5500 filings as a unique ID for the plan. A Plan number should not be re-used for a different plan (even after termination). (We typically default to 501 if a plan number is not provided.)
<b>New Plan or Restatement</b>
If this is a brand new plan for your company, please select 'New' and if you are amending and restating a previous plan, please select 'Restatement'.
<b>Short Plan Year</b>
Short Plan years exist when there is a change in the annual plan year basis. If the ERISA Plan year is not changing, then do not check this box.
<b>Original Effective Date</b>
If this is a restated/amended Plan Document, then the date that the plan first existed is the Original Effective Date.
<b>Restated Date</b>
The date on which any amendments to the Plan (made within the normal plan year) should take effect.

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Please complete this form and submit to HealthEquity with a check\* for the plan set up fee of \$250.

Note: Amendments to plans created by HealthEquity and that are already in effect are \$75. Please allow 30 days to process and return plan documents to the employer. An employer signature on the POP application is required before the plan can take effect.

## Part 1: Company Information

Company Name	Federal Tax Identification Number	State of Incorporation	ERISA Plan Number (if applicable)	
Street Address		City	State	ZIP
Nature of Business				
Employer Entity (check one) <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Limited Liability <input type="checkbox"/> Government or Church <input type="checkbox"/> Other _____				

## Business Principals

CEO Name	CFO Name
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## Primary Contact Information

Plan Administrator Name	Title
Phone	Fax
E-mail	

## Affiliates

If you have affiliates that should be included in your plan documents, please complete an Affiliates Questionnaire as well.

## Part 2: Plan Effective Dates

Plan Name	Plan Number (501 - 530)	
Plan Year Start Date: ____/____/____	Plan Year End Date: ____/____/____	Fiscal Year End Date: ____/____/____
Is this a short plan year? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify Plan Start Date: ____/____/____ and End Date: ____/____/____		
Is this a restatement of a previously adopted plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, effective date of plan restatement ____/____/____		

## Part 3: Plan Design (Please check benefits to be offered under the plan)

<input type="checkbox"/> Medical Coverage premiums	<input type="checkbox"/> Disability Coverage premiums	<input type="checkbox"/> Health Savings Account (HSA) contributions
<input type="checkbox"/> Dental Coverage premiums	<input type="checkbox"/> Term Life Coverage premiums	<input type="checkbox"/> Other Coverage Premiums: _____

## Part 4: Employee Elections

<input type="checkbox"/> <b>Election Required First Year Only</b> - Only a first year POP election is required to be made by employee, evergreen thereafter.
<input type="checkbox"/> <b>Election Required Each Plan Year</b> - Employee is required to re-enroll in POP every plan year in order to continue pre-tax deductions.
<input type="checkbox"/> <b>No Election Required, May Opt-Out</b> - Employee is automatically enrolled in POP, but may elect to "opt-out" and pay taxes on cost of insurance.

## Authorized Signature

I hereby authorize HealthEquity to provide plan administration services based on the information in this Employer Application.		
Name (please print)	Signature	Date

\*When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer from your account if eligible, or to process the payment as a check transaction. Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.