DOCUMENT FEE $_____ DOCUMENT ONLY _____ NEW PLAN___ / RESTATEMENT _____

PREMIUM ONLY PLAN (POP)
PLAN DESIGN WORKSHEET

I. EMPLOYER DATA

Legal Name:			Fed Tax ID:
Street Address:			
Mailing Address:			
City:	State:	Zip:	Phone: ( )
Contact Person:			Fax: ( )
E-mail Address:			State of Incorporation:

Employer Entity:

_____ C Corp _____Partnership _____Nonprofit Corp _____Professional Service

_____ S Corp _____Church _____Sole Proprietorship _____Governmental Entity

_____LLC or LLP _____Tax-Exempt Org.

If the employer is part of a Controlled Group of Companies, list the legal names of the other companies here. Circle the names of affiliated employers who will adopt the Plan:

II. PLAN INFORMATION

Plan #	Original Plan Effective Date	CPN Plan Effective Date	Plan Year Beginning	Plan Year Ending

III. CONTRIBUTIONS

_____ Employee Salary Reductions

IV. ELIGIBILITY REQUIREMENTS

Employees in the following categories will be **excluded**:

_____ Part-time employees working less than _____ hours per week _____ Commission Employees

_____ Under the age of _____ (not to exceed 21 years) _____ Contract Employees

V. PARTICIPATION DATE

_____ First day of each month after _____ days of continuous employment (waiting period)
_____ The day after satisfying eligibility requirements.

VI. BENEFIT OPTIONS

____ Health Savings Account

INSURANCE PREMIUMS:

____ Group Term Life	____ Accident
____ Medical	____ Vision
____ Dental	____ Hospital Indemnity
____ Cancer	____ Intensive Care

VII. ELECTION CHANGES

Changes in election amounts are allowed at the beginning of each new Plan Year. The scope of these acceptable changes are detailed in Section 5.4 of the Plan Document. Any other options may be limited by legal or administrative restrictions.

VIII. BENEFIT ELECTION OPTIONS

A. If an employee elects the eligible insurance benefits on payroll deduction, will you require an enrollment form in order to have that premium deduction set up on a pre-tax basis?

□ YES □ NO

IX. AUTHORIZATION

The Employer hereby agrees to the provisions of this Adoption Agreement, and in witness of its agreement, the Employer by its duly authorized officers, has executed this Adoption Agreement in this _____ day of _____, 20___.

EMPLOYER: _____

BY: _____
Authorized Officer Title

Note:
Corporate Planning Network, Inc., will not accept the responsibility for the accuracy of the administration and/or governmental filings for any plan year prior to your contract date with us. However, on a fee basis, we will prepare IRS reporting forms and are willing to assist you in any problem areas you may have with your past plan administration.