CPNFLEX

SECTION 125 FLEXIBLE BENEFITS PLAN

PLAN DESIGN AND ADOPTION AGREEMENT

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:

Additional Contacts for Access to your Employer Portal:

1. First Name ______________ Last Name: __________________ Phone: _________________
   Email address: _________________________
2. First Name ______________ Last Name: __________________ Phone: _________________
   Email address: _________________________
3. First Name ______________ Last Name: __________________ Phone: _________________
   Email address: _________________________

*If more than three, please notify CPN.

Broker Information:

Name of Company: ____

Broker Contact Name: ____

Phone: ____

Broker Contact Email: ____

Broker Contact Name: ____

Phone: ____

Broker Contact Email: ____

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	CPN Takeover Date	Plan Year Beginning	Plan Year Ending

NOTES: ____

____

III. CONTRIBUTIONS

_____ Employee Salary Reductions
_____ Employer Contributions: ____
_____ Electronic Funds Transfer (authorization required)

IV. ELIGIBILITY REQUIREMENTS

- Employer Waiting Period (# of Days) _______
- Minimum Hours for eligibility _________

_____ Employee is eligible first day following completion of waiting period.
_____ Employee is eligible first of the month following completion of waiting period.

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

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

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

_____ Commission Employees

_____ Contract Employees

V. BENEFIT OPTIONS

INSURANCE PREMIUMS:

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

FLEXIBLE SPENDING ARRANGEMENTS:

Account Type	Plan Year Maximum	Optional Minimum Age	Eligibility Service
____Medical Expenses ($3,300 IRS Maximum)			
____ Dependent Care ($5,000 IRS Maximum)			

______ **Limited Purpose Healthcare FSA** (limited to vision and dental) subject to annual limit of $______________ (IRS Maximum $3,300), for use with HSA.

_______ **Adoption Assistance**

_______ **Tax-Free Parking and Transportation Program**

_______ **Employee Health Savings Account Contributions**

VI. ADDITIONAL CLAIM FEATURES

☐ **CHECK BOX** if employer will have carryover from a previous FSA administrator so a special **plan name** can be set up to receive/post these funds.

_____ Claims Extension Period of 2 ½ months

_____ $660 Carryover:
__ Add Carryover of up to $660, for each Plan Year and **stay** at $660.
__ Add Carryover of up to $660, and automatically adjust to the amount as it is **indexed** for inflation in future plan year.

OR – Set the amount you wish to carryover at ____________ (amount cannot be greater than $660)

(You **cannot** have the 2.5 month extension and the FSA Carryover. It is one or the other.)

VII. CLAIMS REIMBURSEMENTS

Reimbursement checks will be:
_____ mailed directly to employee's address
_____ direct deposited to employee's account

Claims Reimbursement Schedule Day: ____________________
(If left blank, a day of the week, Mon-Fri, will be chosen for you by CPN, Inc.)

Terminated employees will be allowed to file claims for a period of _____ days following date of termination.

Active Employees shall have _____ days ***after*** the end of each plan year to submit expenses against their prior plan year for dates of service that incurred during that eligibility period.

VIII. DEBIT CARD FEATURE

___ Check here to offer debit card to your plan. ___Check here to **NOT** OFFER DEBIT CARD.

Please indicate the claim type linkage you wish to be applied to the debit card:
___ MEDICAL ___ DENTAL ___ VISION ___ RX ___ OTC *

*(There are limited OTC items that are considered qualified; most will require a written prescription from a licensed MD in order to be reimbursed. Or, in order to be purchased with the CPNFLEX debit card, the OTC must be filled at a pharmacy counter and purchased as an RX (RX number to appear on the printed receipt).

INSURANCE CO-PAYS:

Medical Office Visit Co-Pays: ___________________________
Emergency Room Co-Pays: ___________________________
Prescription Co-Pays: ___________________________
Dental Co-Pays: ___________________________
Vision Co-Pays: ___________________________

IX. EXPENSE ALLOCATION

If the employer sponsors a Limited Healthcare FSA in addition to an HSA, eligible medical expenses are paid under the Healthcare FSA,

_____ *Before* the HSA

_____ *Commensurate with* the HSA

_____ *After* the HSA

X. 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.

XI. 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

B. FSA participants who fail to sign a new election form for subsequent Plan Years shall:

____ Continue same elections as prior year, or
____ Be considered to have elected not to participate for upcoming Plan Year

XII. PAYROLL DIVISIONS

Payroll Frequency	First Deduction Date	2nd Deduction Date	# Deductions 1st Plan Year
12 24 26 52			
12 24 26 52			
Other:			

The completion of the above and attached Payroll Calendar (s) **must** be completed in full for each and every payroll your company has available. If you have more than one, please indicate each payroll cycle by color coding on the calendar provided.

☐ **CHECK BOX** if CPN will **bill** Employer's FSA based on disbursements.

Method of payment for FSA payroll contributions:

___ Employer will send via ACH to CPN
___ Employer accepts CPN to pull funds (appropriate document to be completed)

Divisions (aka Departments):

____

____

XIV. 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.

Doc Fee $________________________

Compliance Fee $________________

Monthly Admin Fee $_____________

Other: ___________________________

Employer Name: ______________________________

2025 Payroll Check Date Calendar

January 2025

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April 2025

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May 2025

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 2025

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July 2025

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August 2025

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September 2025

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October 2025

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

December 2025

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

If you have more than one pay cycle please **color** code and indicate below which color is for which payroll cycle.

Employer Name: ____________________________________

2026 Payroll Check Date Calendar

January 2026						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	31	31

February 2026						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

March 2026						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

April 2026						
Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May 2026						
Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

June 2026						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

July 2026						
Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

August 2026						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	14	25	26	27	28	29
30	31					

September 2026						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

October 2026						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

November 2026						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

December 2026						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
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