

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 (\$3,400 IRS Maximum)			
___ Dependent Care (\$7,500 IRS Maximum)			

___ **Limited Purpose Healthcare FSA** (limited to vision and dental) subject to annual limit of \$_____ (IRS Maximum \$3,400), for use with HSA.

___ **Adoption Assistance**

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

___ **Employee Health Savings Account Contributions**

VI. ADDITIONAL CLAIM FEATURES

___ Claims Extension Period of 2 ½ months

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.

___ \$680 Carryover: ___ Add Carryover of up to \$680, for each Plan Year and **stay** at \$680.
 ___ Add Carryover of up to \$680, 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 \$680)

(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

Claim Reimbursements are processed daily.

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	2 nd Deduction Date	# Deductions 1 st 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.

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)

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

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: _____

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	30	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	24	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
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: _____

2027 Payroll Check Date Calendar

January 2027						
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 2027						
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 2027						
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 2027						
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 2027						
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 2027						
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 2027						
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 2027						
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				

September 2027						
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 2027						
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 2027						
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 2027						
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.