COMPENSATION PLANNING INC.

GENERAL INFORMATION

Legal Name of Plan Sponsor:		
Street Address:		
City, State, Zip:		
Phone:		Fax:

Business Type (CHOOSE ONE):

C-Corporation	Partnership	Sole Proprietorship

S-Corporation	LLC

Federal Tax Identification #: _____ Plan #: _____
501,502, etc.

Benefit Coordinator:_____ **President:**_____

NEW PLAN:

Name of Plan:_____Premium Conversion Plan

Effective Date of Plan:_____

AMENDED AND RESTATED PLAN:

Name of Original Plan:_____

Effective Date of Original Plan:_____

AMENDMENT AND RESTATEMENT NOTES:

TYPE OF GROUP COVERAGE ELIGIBLE FOR THE PLAN: (check all that apply)

☐ Health	☐ Dental	☐ Dependent Care
☐ Short Term Disability	☐ Long Term Disability	

Signed:_____ Date:_____

67 Jefferson Boulevard, Warwick, Rhode Island 02888 PH (401) 223-5555 FX (401) 223-5557