



**DENVER RESERVE**  
CORPORATION

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# CAFETERIA PLAN PREMIUM ONLY CHECKLIST

**\$225 \$125 SETUP FEE**  
**(\$100 DISCOUNT FOR COLORADO  
MEDICAL SOCIETY MEMBERS)**

**(Fee must be paid before documents are sent.)**

## 1. Employer:

Name

Street Address

City

State

Zip

Tax ID Number

General Phone Number for Documents

Direct Phone Number

Fax Number

Contact Person

Email

## 2. How do you want the plan documents to be prepared?

- Hard copy in a binder (only).
- PDF file emailed (only).
- Hard copy in a binder and a disk included containing PDF files.

## 3. Plan number (circle one or leave blank if not known): 501 502 503 504

## 4. Employer's principal office (state):

\_\_\_\_\_

## 5. New plan or existing plan:

- New Plan

Effective Date \_\_\_\_\_  
(month, day, year)

or

- Amendment and restatement of existing plan.

Original Effective Date:

\_\_\_\_\_

(month, day, year)

- Attach copy of previous Plan Document and

## 6. Plan year:

(The beginning should be the same as your health insurance open enrollment date.)

Begins:

\_\_\_\_\_

(month, day) (January 1)

Ends:

\_\_\_\_\_

(month, day) (December 31)

## 7. Health insurance plan year:

\_\_\_\_\_

(month, day, year)

## 8. Employer entity:

- S Corporation
- Corporation
- Partnership
- Sole Proprietorship
- Governmental Entity
- Non-Profit Organization
- Limited Liability Company

**9. Eligible class of employees:**

- All employees
- All employees except:
  - Commissioned
  - Union
  - Leased
  - Part-time who work less than \_\_\_\_\_ hours per week.
- Other  
\_\_\_\_\_

**11. Premiums:**

- Health Insurance
- Group-term life Insurance
- Disability Insurance
- Dental Insurance
- Cancer Insurance
- Vision Insurance
- Accidental Death and Dismemberment Insurance
- Other  
\_\_\_\_\_

**10. Eligibility conditions:**

- Same as employer's group medical plan.
- OR**
- Eligibility as follows:
  - Date of hire
  - \_\_\_\_\_ days after date of hire
  - \_\_\_\_\_ months after date of hire

**12. Are medical premiums self-insured:**

- Yes
- No

**13. Will the medical premiums be automatically pretax unless elected otherwise:**

- Yes
- No

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**14. Will there be affiliated employers?**

- No
- Yes

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Tax ID#: \_\_\_\_\_

**15. Broker representative information:**

\_\_\_\_\_  
Name DRC Code Number

\_\_\_\_\_  
Company/Agency

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Telephone Fax E-Mail