

Morgan White Administrators
Employer Administration Information Form

Employer (Exact Legal Name): _____
Business Type: _____ SIC Code: _____
Federal Tax ID Number: _____

Mailing/Billing Address:

Street or PO Box: _____
City: _____ State: _____ Zip: _____

Physical Address (If different from Mailing Address):

Street: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

Plan Fiduciary: _____ Title: _____
Telephone: _____ E-Mail: _____

Contact Person: _____ Title: _____
Telephone: _____ E-Mail: _____

Plan Administrator: _____ Title: _____
Telephone: _____ E-Mail: _____

Registered Agent for Legal Process: _____
Physical Street Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ E-Mail: _____

Requested Effective Date (mm/dd/yyyy) _____

Plan Year Start Date (mm/dd) _____ **Plan Year End Date** (mm/dd) _____

Total # of Employees (Including Part-time): _____ **# of Eligible Employees:** _____

Payroll Frequency: Weekly Bi-Weekly Monthly Bi-Monthly

First Payroll Date: _____

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Reason for completion of this form:

PCP New Change IRS Plan # _____

Plan Name: _____

HRA New Change IRS Plan # _____

Plan Name: _____

FSA New Change IRS Plan # _____

Plan Name: _____

DCA New Change IRS Plan # _____

Plan Name: _____

COBRA Administration

Discrimination Testing Requirements:

Business Structure: (ie: C Corporation, Sub S, LLC, etc.) _____

Please list all Officers, Directors, 5% Shareholders, or Highly Compensated (Individuals who received more than \$85,000 income during the preceding year) individuals.

Name	Title	Income
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____