**1. DOCUMENT TYPE**

Cafeteria Plan

b. ☐ Flexible Spending Account Plan (Includes Adopting Resolution)
   1. ☐ Include Trust Document
   2. ☐ No Trust Document

c. ☐ No Plan (Supporting Forms Package Only)

Supporting Forms Package

d. ☐ Include all forms (SPD 8.5 x 11 and Administrative Forms)
e. ☐ Administrative Forms Only
f. ☐ SPD only
g. ☐ No Supporting Forms

Footer for 8.5" x 11" SPD

h. ☐ Yes _____
i. ☐ No

**DRAFTING PREFERENCES**

j. ☐ Standard (single, ragged)
k. ☐ Single, right justified
l. ☐ Double, ragged
m. ☐ Double, right justified

**FONT OPTIONS**

n. ☐ 9 pt. Times
o. ☐ 8.5 pt. Arial

---

**FIS Client Name**

p. _____

q. _____

**AGREEMENT**

By selecting each of the following you are agreeing to the terms of the use of this FIS plan. **WARNING**: Failure to complete these selections can result in your checklist not being saved correctly.

r. ☐ The plan being prepared is solely for the use of the employer indicated in the plan (the "adopting employer") as well as any participating employers to such plan. The use of the plan for any other employers is strictly prohibited.

s. ☐ FIS will notify you of, and provide, any required updates in accordance with FIS's usual business practices (generally email notification and/or Technical Updates). You agree to monitor any legislative and regulatory developments that may affect the plan and agree to hold FIS harmless in the event FIS does not provide you with the notification of any required amendments.

**EMPLOYER INFORMATION**

**2. Name of Employer:** (exactly as it is to appear with punctuation)

a. _____

b. _____

**3. Employer's Address:**

a. _____ (Street--Physical not P.O. Box)

b. _____ (City) c. _____ (State) d. _____ (Zip)

e. Telephone ( ) _____

**4. Employer's Tax ID No.:** a. _____

**5. Plan Number:** a. _____

**6. Plan Administrator shall be:**

a. ☐ Employer, using Employer's address

**OR**

b. ☐ Other _____ (Name)

**AND,** if Other selected

c. ☐ Use Employer's address
d. ☐ Use address below...

1. _____ (Street--Physical not P.O. Box)
2. _____ (City) 3. _____ (State) 4. _____ (Zip)
5. Telephone ( ) _____

**7. Plan's Agent for service of legal process is:**

a. ☐ Employer, using Employer's address
b. ☐ Plan Administrator
c. ☐ Other _____ (Name)

**AND** (for Plan Agent's address)

d. ☐ Use Employer's address (automatically selected if **7a** chosen)
e. ☐ Use address below...

1. _____ (Street--Physical not P.O. Box)
2. _____ (City) (State) (Zip)

**8. Employer's Principal Office:** a. _____ (State)

**9. Plan Information:**

a. ☐ New Plan
b. ☐ Amendment and Restatement

**AND,** is this Plan a "wrap" plan for Form 5500 filing purposes?

c. ☐ Yes
d. ☐ No

**10. Plan Name/Title of Document:** (exactly as it is to appear with punctuation)

a. _____

b. _____

c. _____

**11. Plan Year:**

a. Begins _____
(month) (day)

b. Ends _____
(month) (day)

Is there a short Plan Year?

c. ☐ Yes, beginning _____
(month) (day)

1. ☐ and ending on _____
(month) (day)

d. ☐ N/A

**12. Effective Date(s):**

a. Initial Effective Date _____
(month) (day) (year)

b. This Restatement _____
(month) (day) (year)

**13. Employer Entity:**

a. ☐ S Corporation (2% shareholders not eligible)
b. ☐ Corporation
c. ☐ Partnership (self-employed (partners) not eligible)
d. ☐ Sole Proprietorship (self-employed not eligible)
e. ☐ Governmental Entity or Church
f. ☐ Non-Profit Organization
g. ☐ Limited Liability Company (members not eligible)

**Note:** **13a, c., d.,** & **g.,** add a provision that excludes the group in parentheses from participating in the plan.

## ELIGIBILITY

**14. Eligible Class of Employees:**

a. ☐ All Employees who satisfy eligibility requirements
b. ☐ Salaried Employees only
c. ☐ Hourly Employees only
d. ☐ All Employees except:
1. ☐ Commissioned Employees
2. ☐ Union Employees
3. ☐ Leased Employees
4. ☐ Part-time Employees, expected to work less than _____ hours per week
5. ☐ Nonresident Aliens
6. ☐ Employees not eligible under the Employer's group medical plan
7. ☐ Those who have not completed _____ Hours of Service (if left blank, default will be 1 Year of Service (1000 hours))
8. ☐ Those who have not attained age _____ (cannot exceed 21; if left blank, default will be age 21)
9. ☐ Other _____

**Note:** If using Simple Cafeteria Provisions and selecting d., only **2**, **5**, **7 and 8** can be selected.

**15. Conditions for Eligibility:**

a. ☐ Same as Employer's group medical plan

**OR**

b. ☐ For **first** Plan Year **only**, anyone employed on the effective date of the Plan is eligible, **thereafter**:
(choose one from **e.** - **g.** below)

**OR**

c. ☐ For **all** years, eligibility is as follows:
(choose one from **d.** - **g.** below)
d. ☐ Date of hire (no service required)
e. ☐ _____ years after date of hire
f. ☐ _____ days after date of hire
g. ☐ _____ months after date of hire

**AND**

**For Health Flexible Spending Account only,** eligibility is as follows:

h. ☐ No Health Flexible Spending Account, or eligibility is the same as above for all benefits
i. ☐ _____ days after date of hire
j. ☐ _____ months after date of hire
k. ☐ _____ years after date of hire

**Note:** If option **i., j.** or **k.** selected, **21l** must be selected.

**16. Entry Date:**

a. ☐ First day of the pay period next following date requirements were met
b. ☐ Date conditions for eligibility are met
c. ☐ Dual entry (1st day of Plan Year & 6 months later)
d. ☐ First day of Plan Year following date requirements were met
e. ☐ First day of month following date requirements were met
f. ☐ Same as Employer's group medical plan

**17. Family and Medical Leave Act:** Is the Employer subject to these provisions?

a. ☐ No
b. ☐ Yes

## CONTRIBUTIONS

**18. Contributions.** Plan will provide for...

a. ☐ Salary reduction contributions **ONLY** (no Employer contributions) (skip to **20**)
b. ☐ Employer contributions **ONLY** (no salary reductions) (answer **19**, then skip to **21**)
c. ☐ Both salary reductions **AND** Employer contributions
1. ☐ Simple Cafeteria provisions ONLY (skip **19**, answer **40**)
2. ☐ Simple Cafeteria provisions AND additional Employer contributions (answer **19** and **40**)
3. ☐ N/A. No Simple Cafeteria provisions.

**Note:** Salary reduction contributions are set at the amount sufficient to cover a Participant's benefit elections.

**Note:** If Employer contributions are only paying a portion of the cost of insurance with no cash option, select **18a**

**19. Employer Contributions.** For each Plan Year, Employer will contribute...

☐ N/A
a. ☐ _____% of compensation per Participant
b. ☐ $_____ per Participant
c. ☐ Discretionary
d. ☐ Other _____
e. ☐ "Opt Out" (payment if health coverage waived)

**AND,** the contributions shall be made...

f. ☐ At beginning of Plan Year
g. ☐ Pro rata each pay period

**AND,** the contributions are convertible to cash
h. ☐ Yes
i. ☐ No
**Note:** Option **i.** may not be selected with **18b** or **19e**

**AND,** the contributions are to be made to: (select **j.** or all that apply from **k. - m.**)
j. ☐ All accounts
k. ☐ Health FSA (must answer **24**)
l. ☐ Health Savings Account (must answer **25**)
m. ☐ Dependent Care FSA (must answer **21m)**

## BENEFIT OPTIONS

**20. Benefit Options.** Plan to provide...
k. ☒ Flexible Spending Accounts. (automatically selected)

**21. Flexible Spending Accounts** will be established for... (select all that apply)
l. ☐ Health Flexible Spending Account
m. ☐ Dependent Care Flexible Spending Account
n. ☐ Adoption Assistance Flexible Spending Account
**Note:** The terms of the Health Flexible Spending Account are set below at **24.** For the Dependent Care Flexible Spending Account and Adoption Assistance Flexible Spending Account, statutory maximums and terms are standard in the Flexible Spending Account Plan.

**AND** include account for insurance premium payments
o. ☐ Yes, include Premium Payment Account -- must check options **a.** through **k.** below
p. ☐ No (skip to **24**)

**Premium Payments** may be elected for...
a. ☐ Health insurance (employee AND dependent coverage)
**OR**
b. ☐ Dependent health insurance ONLY
**OR**
c. ☐ No group health insurance
**AND**
d. ☐ Group-term life insurance
e. ☐ Disability insurance
f. ☐ Dental insurance
g. ☐ Cancer insurance
h. ☐ Vision insurance
i. ☐ Accidental Death and Dismemberment insurance
j. ☐ Prescription Drug Coverage
k. ☐ Other Insurance Coverage
**Note:** **k.** adds language that allows for other types of health coverage not listed above.

**22. Are the health premium payments elected above self-insured by the Employer?**
a. ☐ Yes
b. ☐ No

**23.** May Participants seek reimbursement for individual policies through the Premium Conversion Plan?
a. ☐ N/A
b. ☐ Yes, at the Administrator's discretion
c. ☐ No

**24. Health Flexible Spending Account (Health FSA) Options:** (select as applicable)
a. ☐ N/A (No Health Flexible Spending Account, skip to **25**)
b. ☐ Limit for Health Flexible Spending Account: (select one of 1 or 2; select 3 -5 as applicable)
1. ☐ $_____ is the maximum amount to be contributed to the Health FSA (includes all contribution sources)
2. ☐ The maximum statutory amount allowed, as adjusted for cost of living (includes salary reductions and Employer contributions convertible to cash, if applicable)

For the limit above, if there are Employer contributions NOT convertible to cash (19i selected)
a. ☐ Are included in limit at b.
b. ☐ Are subject to separate limit of: $_____

**AND,** further restrictions shall apply: (select all that apply)
3. ☐ the minimum amount to be contributed shall be: $_____
4. ☐ for a short Plan Year, $_____ is the maximum amount to be contributed to the Health Flexible Spending Account
5. ☐ if an Eligible Employee enters the Plan mid year, $_____ is the maximum amount to be contributed to the Health Flexible Spending Account

**AND,** amounts can be carried over: (select all that apply)
6. ☐ N/A (no carryover or grace period applies)
7. ☐ $_____ can be carried over for use in the following Plan Year (maximum is $500). NOTE: Grace Period for Health FSA (**33b**) CANNOT be selected).

Further Conditions (select all that apply):
a. ☐ $_____minimum carryover
b. ☐ Carryover only through next Plan Year
c. ☐ Carryover only if elect to participate for next Plan Year

**AND,** Terminated Employees shall... (select one)
c. ☐ N/A--COBRA applies
d. ☐ Continue contributions and reimbursements for the remainder of the Plan Year
e. ☐ Cease contributions and reimbursements upon termination
f. ☐ Continue or cease at Participant's election

**AND,** new election due to change in status permitted? (select one)
g. ☐ No
h. ☐ Yes
i. ☐ Yes, only if salary redirections to the Health FSAs are increased

**AND,** the Health FSA will be limited to the following types of medical expenses… (select j. or all that apply from k. - l.) (if HSA selected at 25, must select k or l).
j. ☐ N/A
k. ☐ certain types of expenses only: (select all that apply)
1. ☐ dental expenses
2. ☐ vision expenses
3. ☐ preventive expenses
l. ☐ only expenses in excess of the HDHP deductible

**FOR**
m. ☐ all Participants
n. ☐ only HSA contributing Participants

**AND,** claims for medical expenses can only be submitted for:
- o. ☐ the Participant
- p. ☐ the Participant and all dependents

**Note:** If medical expenses are not limited, HSA eligibility may be affected.

## MISCELLANEOUS PROVISIONS

**25. Health Savings Account provided by Employer?**
- a. ☐ Yes
- b. ☐ No

**26. Benefit Election Period shall be...**
- a. ☐ The _____ day period prior to each Plan Year
- b. ☐ From the _____ day to 1. _____ day period prior to each Plan Year
- c. ☐ Established by Administrator in nondiscriminatory manner

**27. Is automatic enrollment for insured benefits provided under this Plan?**
- a. ☐ Yes
- b. ☐ No

**28. Participants who fail to sign** a new election form shall...
- a. ☐ Be considered to have elected not to participate for upcoming Plan Year (may not be selected with **27a**)
- b. ☐ Continue same elections as prior year only for insured benefits (may only be selected with **21o**)

**29. Witnesses to Employer's signature:**
- a. ☐ Yes
- b. ☐ No

**Note:** State law may require witnesses to the Employer's signature. Relius does not have this information.

**30. Is a 401(k) Plan a benefit under this Cafeteria Plan?**
- a. ☐ Yes, name of Plan: _____
- b. ☐ No or N/A

**31. May Participants convert vacation days** into Cafeteria Plan benefit dollars?
- a. ☐ Yes
- b. ☐ No

**32. "Grace Period"** Extend the time to incur expenses past the end of the Plan Year:
- a. ☐ Yes
- b. ☐ No

**AND,** extend the time period by how long? (select one)
- c. ☐ _____ days (maximum 75)
- d. ☐ 2 1/2 months after the end of the Plan Year (March 15 for a calendar year plan)

**AND,** allow up to what amount? (select one)
- e. ☐ Entire remaining account balance
- f. ☐ $_____

**AND,** for which accounts?
- g. ☐ Health FSA
- h. ☐ Dependent Care FSA
- i. ☐ Adoption Assistance FSA

**33. Claims for Reimbursement must be filed within Health FSA:** (must select **a.** or **b.**; **c.** is optional in addition to **a.** or **b.**)
- a. ☐ _____ days following each Plan Year (e.g., 60)
- b. ☐ _____ days following the Grace Period (e.g., 60) (may not be selected with **32.b.**)

**AND,** for Participants who terminate employment, will a different filing deadline apply? (optional, leave blank if N/A)
- c. ☐ _____ days following termination of employment (e.g., 60)

**Dependent Care FSA:** (must select **d.** or **e.**; **f.** is optional in addition to **d.** or **e.**)
- d. ☐ _____ days following each Plan Year (e.g., 60)
- e. ☐ _____ days following the Grace Period (e.g., 60) (may not be selected with **32b**)

**AND,** for Participants who terminate employment, will a different filing deadline apply? (optional, leave blank if N/A)
- f. ☐ _____ days following termination of employment (e.g., 60)

**Adoption Assistance FSA:** (must select **g.** or **h.**; **i.** is optional in addition to **g.** or **h.**)
- g. ☐ _____ days following each Plan Year (e.g. 60)
- h. ☐ _____ days following the Grace Period (e.g., 60) (may not be selected with **32b**)

**AND,** for Participants who terminate employment, will a different filing deadline apply? (optional, leave blank if N/A)
- i. ☐ _____ days following termination of employment (e.g., 60)

**34. Claims should be submitted to:**
- a. ☐ Employer, using Employer's address
- b. ☐ _____ at address below:
  - 1. _____ (Street--Physical not P.O. Box)
  - 2. _____ (City) (State) (Zip)

**35. Are employer provided debit or credit cards used for expenses through Flexible Spending Accounts?**
- a. ☐ Yes **AND,** for which accounts?
  - 1. ☐ Health FSA (may only be selected with **21l**)
  - 2. ☐ Dependent Care FSA (may only be selected with **21m**)
- b. ☐ No

**36. Add COBRA?** (**a.** must be selected if **24c** chosen, **b.** must be selected if **24d, e.,** or **f.** chosen)
- a. ☐ Yes
- b. ☐ No

**37. Is the Plan subject to HIPAA?**
- a. ☐ Yes
- b. ☐ No

**38. HEART Act.** Add Qualified Reservist Distribution (QRD) provisions for Health FSA:
- a. ☐ N/A or No (skip to **39**)
- b. ☐ Yes

**AND,** select distribution amount (all amounts minus reimbursements paid) (select one):
- c. ☐ the beginning of year FSA amount
- d. ☐ amount contributed up to point of distribution request
- e. ☐ $_____ (cannot exceed beginning of the year FSA amount)

**AND,** how many distributions per year?
- f. ☐ _____ per year

**AND,** claims submitted after QRD (select one):
- g. ☐ be paid on submission as any other claim
- h. ☐ shall not be paid

**39. Dependent Care and Adoption Assistance Flexible Spending Account Maximums.** The statutory maximums for Dependent Care and/or Adoption Assistance will be the maximums for Plan unless elected below. Options **b. - d.** may be added if the statutory maximums are selected. (select all that apply; leave blank if not applicable)
- a. ☐ The statutory maximum is replaced by the amount below:
  - 1. ☐ $_____ for Dependent Care FSA
  - 2. ☐ $_____ for Adoption Assistance FSA

**AND,** will there be a minimum?
- b. ☐ Yes
  - 1. ☐ $_____ for Dependent Care FSA
  - 2. ☐ $_____ for Adoption Assistance FSA

**AND,** for a short Plan Year, will there be a different maximum?
- c. ☐ Yes
  - 1. ☐ $_____ for Dependent Care FSA
  - 2. ☐ $_____ for Adoption Assistance FSA

**AND,** if an Eligible Employee enters the Plan mid-year, will there be a different maximum?
- d. ☐ Yes
  - 1. ☐ $_____ for Dependent Care FSA
  - 2. ☐ $_____ for Adoption Assistance FSA

## HEALTH CARE REFORM PROVISIONS

**40. Simple Cafeteria plan (for employers with 100 or fewer employees):**
- a. ☐ Yes, effective _____
- b. ☐ No

**AND,** the Employer Contribution shall be... (select one)
- c. ☐ ____% (not less than 2%) of a Participant's Compensation
- d. ☐ Matching contribution equal to ____% of compensation but in no event more than ____% (cannot be less than 6% of compensation)

**AND,** the contributions are convertible to cash
- e. ☐ Yes
- f. ☐ No

**41. Coverage for Children provided in Health FSA?**
- a. ☐ Yes
- b. ☐ No

**42. Change in Status:** New Provisions for employee change (due to reduction in hours or enrollment in exchange):
- a. ☐ Yes
- b. ☐ No

## SPD PROVISIONS

**43. SPD.** COLA - update the SPD for the 2021 limits (optional) (Note: The SPD and forms currently reflect the 2020 dollar limitations). Include amounts for the 2021 tax year as follows (select all that apply):
- a. ☐ Health FSA dollar limit (may only be selected with 24b2): $ _____
- b. ☐ Adoption Assistance FSA dollar limit (may only be selected with 21n): $_____
- c. ☐ HSA statutory deductible (may only be selected with 24l):
  - 1. Individual: $_____
  - 2. Family: $_____

**Skip to 60**

## ADOPTING EMPLOYERS

**60. Will Adopting Employers execute this Plan?**
**Note:** Selecting "Yes" will generate a Supplemental Participation Agreement.
- a. ☐ N/A or No
- b. ☐ Yes

**First Adopting Employer**

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the first Adopting Employer is?**
- c. ☐ S Corporation (2% shareholders not eligible)
- d. ☐ Corporation
- e. ☐ Partnership (self-employed (partners) not eligible)
- f. ☐ Sole Proprietorship (self-employed not eligible)
- g. ☐ Governmental Entity or Church
- h. ☐ Non-Profit Organization
- i. ☐ Limited Liability Company (members not eligible)

**61. Will there be a second Adopting Employer?**
- a. ☐ No
- b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the second Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**62. Will there be a third Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the third Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**63. Will there be a fourth Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND,** the fourth Adopting Employer is?

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**64. Will there be a fifth Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the fifth Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**65. Will there be a sixth Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the sixth Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**66. Will there be a seventh Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the seventh Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**67. Will there be an eighth Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the eighth Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**68. Will there be a ninth Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the ninth Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)

**69. Will there be a tenth Adopting Employer?**

a. ☐ No
b. ☐ Yes

1. _____ (Name)
2. _____ (Street)
3. _____ (City) (State) (Zip)
4. _____ (ID No.)

**…AND, the tenth Adopting Employer is?**

c. ☐ S Corporation (2% shareholders not eligible)
d. ☐ Corporation
e. ☐ Partnership (self-employed (partners) not eligible)
f. ☐ Sole Proprietorship (self-employed not eligible)
g. ☐ Governmental Entity or Church
h. ☐ Non-Profit Organization
i. ☐ Limited Liability Company (members not eligible)