HRA Plan Document - Fax Order Form

This is a fillable PDF form. Click on the line next to "First Name" to begin and then tab from field to field. Once the form is completed, print, sign, and fax it back to Core Documents at (941) 795-4802. If you need help completing this application call 1-888-755-3373.

You may also print a blank form and write in the information. Please print clearly.

Purchaser Information (Person buying document for Employer listed below, i.e. Agent, CPA, payroll co., etc.)

First Name______________________________ Last Name______________________________
Company ____
Address____
City______________________________ State__________ Zip Code________________
Phone ______________________________ Fax ____________________________________
Email____
Ship Document to: ☐ Purchaser ☐ Employer

Employer Information for Plan Documents – Exactly as it should appear in the plan document. Print clearly.

First Name________________ Last Name__________________ (owner/controller, document signer)

Company Name____
Address ____
City______________________________ State__________ Zip Code________________
Phone______________________________ Fax____________________________________
Email____

Form of Business: ☐ S Corporation ☐ C Corporation ☐ LLC ☐ Partnership ☐ Sole Proprietorship
☐ Government ☐ Non-Profit 501(c)(3)

Employer Federal ID#: ______________ State of Inc.:__________ Number of Employees:________

Legal Name(s) of **Affiliated Company(ies)** that will be covered by the Plan (if any):
1)____
2)____
3)____

Name of Plan Administrator (Employer unless otherwise listed):
Name____
Address____
City______________________________ State__________ Zip Code________________
Phone______________________________ Fax____________________________________

Protected Health Information (PHI) Designee: ____

Effective Date will be:
☐ a) a new plan effective date as of (date)______________
☐ b) Amend and restate an existing HRA plan as of (new date for this updated plan): __________
If this is to be an amended and restated plan, state the (old) original effective date:__________

Plan Year - The first plan year will be:
☐ a) a 12 consecutive month period beginning (date)________ and ending (date)________
☐ b) a short plan year beginning (date)________ and ending (date)__________

Waiting Period: Employees can participate the ☐ 1st day of employment, or ☐ 1st day following, or ☐ 1st day of month following ______ days of employment.

Eligibility Requirements: All employees who work ______ or more hours per week.

Please tell us how you found Core Documents: ☐ Search Engine ☐ Agent ☐ Google Ad ☐ Other________

Core Documents Inc.

If you need help completing this application call 1-888-755-3373

Employer:____ **HRA - Fax Order Form**

A Core Benefit Consultant will contact you regarding your custom plan design requests, issues, and design criteria.
Please answer all of the following basic design questions that apply to the HRA benefit that you would like to provide.
Attach additional design criteria or notes to this order form if necessary.

Comprehensive Plan Questions:

Will your HRA plan have an annual benefit limit? ☐ Yes **OR** ☐ No If yes designate the annual limit: $____________
Will your HRA make the funds available: ☐ Monthly **OR** ☐ Lump Sum
Will your HRA Plan reimburse individual or Exchange insurance premium post-tax? ☐ Yes **OR** ☐ No
Will your HRA carry over unused funds at the end of the plan year? ☐ Yes **OR** ☐ No

Deductible Gap Questions:

Will your HRA Plan be coupled with your group health insurance plan? ☐ Yes **OR** ☐ No
Will your HRA Plan be designed primarily to pay a portion of the deductible? ☐ Yes **OR** ☐ No
Is your group health insurance Plan compatible with a Health Savings Account (HSA)? ☐ Yes **OR** ☐ No
Is the benefit for a calendar year Deductible? ☐ Yes **OR** ☐ No Or a Plan Year Deductible? ☐ Yes **OR** ☐ No
Is your HRA only reimbursing "in-network" provider expenses? ☐ Yes **OR** ☐ No
Is the Employee responsible for some portion of the Deductible and/or other expenses? ☐ Yes **OR** ☐ No
Please describe the Employee responsibility in your notes. Or attach notes to this order.

Premium Reimbursement Questions:

Will your HRA plan be primarily for secondary premium reimbursement (i.e. dental or vision)? ☐ Yes **OR** ☐ No
Will your HRA Plan reimburse individual or Exchange insurance premium post-tax? ☐ Yes **OR** ☐ No

NOTES:____

Choose either the HRA 'Deluxe Binder Option' or the 'Basic PDF Option':

☐ **Deluxe Binder – New Health Reimbursement Arrangement Plan Document** **$349.00** ☐
In email PDF version processed ASAP, AND Printed in 3-ring binder, with
5 Section tabbed index, shipped via Priority Mail.

OR

☐ **Basic PDF Option - New Health Reimbursement Arrangement Plan Document** **$299.00** ☐
PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the HRA Deluxe Binder or the Basic PDF Option:

☐ **Plan Document CD Mailed - in addition to PDF email and/or mailed binder** **$25.00** ☐
Documents provided in PDF format only. Forms in MS Word format.
Always have a safe backup copy of your plan document on CD.

☐ **Rush Order - Your order automatically queued for immediate processing** **$25.00** ☐

☐ **2nd Year Update - discounted 23% when added to new document order** **$149.00** ☐
This option entitles you to one plan document amendment in the first 24 months.
Save 25% off the normal $199.00 update price.

Update and Amend a HRA plan document originally produced by Core Documents:

☐ **Update/Amend Health Reimbursement Arrangement HRA Plan Document** **$199.00** ☐
All Updated/Amended documents delivered via email in PDF format.

TOTAL $ TOTAL

Core Documents Inc.

If you need help completing this application call 1-888-755-3373

Employer:____ **HRA - Fax Order Form**

If paying by check, please complete the following:

Your order can be processed with a copy of the original check attached to the order made out to Core Documents with amount to be charged, OR simply provide the following information and authorization.

Name as it appears on check:

____

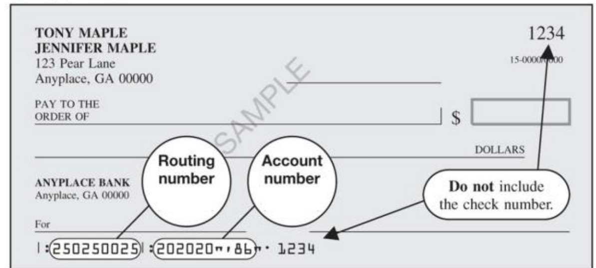
Bank Name: ____

Bank Routing Number: ______________________________

Bank Account Number: ______________________________

Total amount to be charged: $____________

Sample Check



CAUTION *The routing and account numbers may be in different places on your check.*

X____ Date: __________________
Signature

If paying by credit card, please complete the following:

Card Type: r Discover r VISA r MasterCard r American Express

Card Number: __________ __________ __________ __________

Expiration Date: ____ /____

3 Digit Security Code on back:_________
(4 digit on American Express front)

Total amount to be charged: $____________

Security Code

Name as it appears on card: ____

X____ Date: __________________
Signature

Refund Policy: Purchaser understands that goods and services provided by Core Documents, Inc. are non-refundable. Orders cancelled prior to sending/shipping are subject to cancellation fees applied to the cost of goods and services provided during the review, draft, and preparation of your order.

Please sign and fax completed form to (941)795-4802. Attach additional pages of plan design information if needed.

Mail: Core Documents, Inc. P.O. Box 14538, Bradenton, FL 34280
Office: 501 Village Green Parkway, Ste. 22, Bradenton, FL 34209
Scan and Email: CoreService@CoreDocuments.com
Toll Free Voice: 888-755-3373 Fax: 941-795-4802