Core FSA | Health FSA Plan Document

If you have questions while completing this worksheet, please call us at 1-888-755-3373.

Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Core FSA plan document package. It is a fillable PDF form. Click on the line next to "First Name" to begin and then tab from field to field. You may also print a blank form and write in the information. When the form is complete, go to www.corefsa.com to order your package online.

Purchaser Information (Person buying document for Employer listed below, i.e. Agent, CPA, payroll co., etc.; "N/A" in "First Name" if not applicable.)

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_____

Health FSA Annual Plan Limit: The IRS limits Health FSA plans to $3,300 in employee contributions. Choose the standard $3,300 option or designate a lower employee contribution limit here. ❑ $3,300 **OR** ❑Other_____
Choose year end carryover provision for unused funds: ❑ $660 Carryover, **OR** ❑ 2.5 Month Grace Period
Protected Health Information (PHI) Designee Name:_____

Effective Date will be:
❑ a) a new plan effective date as of (date)_____
❑ b) Amend and restate an existing Health FSA plan as of (new date for this updated plan): _____
If this is 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_____

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Employer:_____

Choose either the Health FSA 'Deluxe Binder Option' or the 'Basic PDF Option':

☐ **Deluxe Binder – New Core Health FSA Plan Document** **$199.00** ☐

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 Core Health FSA Plan Document** **$149.00** ☐

PDF Document Processed Quickly and Sent Via E-Mail

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

☐ **Plan Document on USB Drive 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 USB drive.

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

Combine the Health FSA with these options at a discount:

☐ **Premium Only Plan – pre-tax insurance premium** - Save 33% when added to the Health FSA **$100.00** ☐

Eliminate income tax on group premium. Employee saves up to 35% average, and the Employer saves matching FICA at 7.65%+. This benefit pays dividends.

Name of Benefit Programs To Be Offered:

❑ Health Insurance ❑ Dental Insurance ❑ Vision Care ❑ Group Term Life to $50,000
❑ Accident Insurance ❑ Cancer Insurance ❑ Other_____

☐ **HSA Module - pretax HSA savings for additional 7.65% tax savings** **$30.00** ☐

Allows employees to pre-tax Health Savings Account dollars for an additional 7.65% FICA savings (Employer saves matching 7.65% FICA) not available if itemized at year end.

☐ **Dependent Care Assistance Plan (FSA) Pretax childcare -** Save 33% when added to Health FSA **$100.00** ☐

Save 33% off normal $149 DCAP FSA price when added to the Health FSA.
DCAP employee contributions set at $5000 by the IRS. Delivered via email in PDF format unless the binder option is chosen above.

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

☐ **Update/Amend a Premium Only Plan Document - Save 15%** **$129.00** ☐

☐ **Update/Amend a Health FSA Plan Document - Save 15%** **$129.00** ☐

☐ **Update/Amend a Dependent Care FSA Plan Document - Save 15%** **$129.00** ☐

☐ **Update/Amend any 2 plan combination Document - Save 15%** **$259.00** ☐

☐ **Update/Amend a full 3 plan Cafeteria Document - Save 17%** **$299.00** ☐

All Updated/Amended documents delivered via email in PDF format.

TOTAL $ TOTAL

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Invoice me via email, please complete the following:

Company Name: _____ **Contact:** _____

Email Address for Invoice: _____

If paying by check, please complete the following:

Your order can be processed with the following checking account information and authorization.

Name as it appears on the check:

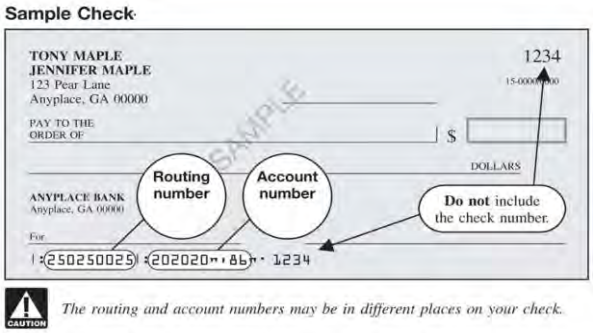
_____

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____



X_____ Date: _____
Signature

If paying by credit card, please complete the following:

Card Number: _____

Expiration Date: ____ /____

Total amount to be charged: $_____

Name as it appears on card: _____

X_____ Date: _____
Signature

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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
Scan and Email: CoreService@CoreDocuments.com
Toll Free Voice: 888-755-3373 Fax: 941-795-4802