Core SPD | Wrap SPD Plan Document

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

When this form is complete, please go to www.corespd.com to order.

Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Core HSA 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.

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 _____ Mobile _____ Fax _____

Email _____ Web site _____

Ship Plan Document package to: ☐ Purchaser ☐ Employer

Employer Information for SPD

(Owner/controller, document signer; exactly as it should appear in the SPD. Company and contact will also be the Plan Sponsor, Agent for Legal Process, Plan Administrator, and Plan Fiduciary.)

First Name _____ Last Name _____

Company Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Mobile _____ Fax _____

Email _____ Web site _____

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

Employer Fed. ID # _____ State of Incorporation _____ No. of Employees _____

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

1) _____ FEIN#_____

2) _____ FEIN#_____

3) _____ FEIN#_____

Plan Administrator

☐ Employer (use 'employer' information, above) ☐ Other (provide information below)

First Name _____ Last Name _____

Company _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

Name of Fully Insured Plan Insurance Carrier(s): (i.e. Blue Cross Blue Shield or Aetna Health Insurance)

☐ Health Insurance Carrier 1: _____

☐ Health Insurance Carrier 2:_____

☐ Health Insurance Carrier 3: _____

Effective Date

☐ A new plan with an effective date of _____.

☐ Amend and restate an existing Section 125 POP as of _____.

If this is an amended and restated plan, state the (old) original effective date: _____.

Plan Year The first plan year will be:

☐ A 12-month consecutive period beginning date _____ and ending date _____.

☐ A short plan year beginning date _____ and ending date _____.

Waiting Period Employees are eligible to participate in the plan on: ☐ the 1st day of employment, or ☐ the 1st day following, or ☐ the 1st day of the month following _____ days of employment.

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

Funding Mechanism: ☐Employer General Assets ☐Employee Contributions ☐ Trust Account ☐Union or Collective Bargained Agreement ☐Other Employee Organization

Assigned Plan Number: ☐501 ☐502 ☐503 ☐ _____ Plan identification for reporting purposes.

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Documenting Method for Identifying Full-Time Employees: (Search - IRS Notice 2012-58 for information)

☐**Monthly Measurement Period** ☐**Look Back Period Alternative Method** Effective in 2014, the health care reform law imposes penalties on employers with **at least 50 full-time equivalent employees** if they do not offer health coverage to their employees or if they offer health coverage to their employees that is not "affordable" or does not provide "minimum value" and certain other requirements are met. The Core Wrap SPD defaults to the standard *Monthly Measurement Period* where every employee working 31 or more hours last month are full-time. The *Look Back Period* alternative method is for groups with employees who work a flexible schedule (or as needed) and there is no way to actually determine if they will be full-time (for purposes of the ACA fines) or part time (30 hours or less). The *Look Back Method* allows for a Safe Harbor period of time, determined by the employer, of not less than 3 months, and not more than 12 months for identifying full- time or part-time status.

Notice of Patient Protections and Selection of Providers:

If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

Does your health insurance require the designation of a Primary Care Provider: ☐Yes ☐No

Notes: Please include any additional information you believe is relevant to your Plan(s) here.

_____

_____

_____

_____

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

☐ **Deluxe Binder – New Core Group Insurance SPD Wrap Plan Document** **$199.00** ☐

In email PDF version processed ASAP, AND Printed in 3-ring binder, with tabbed index, shipped via Priority Mail.

OR

☐ **Basic PDF Option - New Core Group Insurance SPD Wrap** **$149.00** ☐

PDF Document Processed Quickly and Sent Via E-Mail

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

☐ **Supplemental/Ancillary Insurance SPD Module** **$30.00** ☐

Include supplemental/ancillary benefit insurance plans such as dental, vision, critical Illness plans, hospital indemnity, STD, LTD, life etc.

List the Supplemental Insurance Carriers and Benefit Plan Name:

- ❑ Dental Insurance: _____
- ❑ Vision Insurance: _____
- ❑ Group Term Life Insurance: _____
- ❑ Accidental Death Dismemberment Insurance: _____
- ❑ Short Term Disability Illness Insurance: _____
- ❑ Long Term Disability Illness Insurance: _____
- ❑ Accident Insurance: _____
- ❑ Critical Illness Insurance: _____
- ❑ Cancer Insurance: _____
- ❑ Intensive Care Insurance: _____
- ❑ Life Insurance: _____

☐ **Self-Funded Health Plan Module** **$30.00** ☐

Name of TPA: _____

Name of Reinsurance Carrier: _____

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

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:

_____

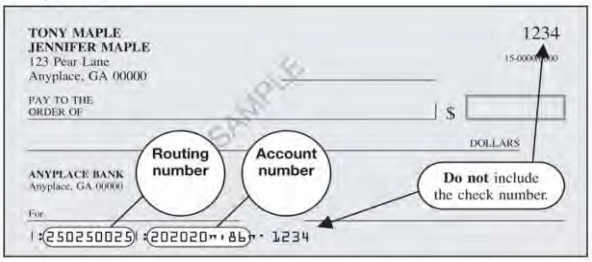
Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____

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 Number: _____

Expiration Date: ____ /____

Total amount to be charged: $_____

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