Group Insurance Wrap SPD 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, TPA, agent, etc.)

First Name_______________ Last Name_______________

Company _______________

Address_______________

City_______________ State_______________ Zip Code_______________

Phone _______________ Fax _______________

Email_______________

Email/Ship Document to: ❑ Purchaser ❑ Employer

Employer Information for SPD – Exactly as it should appear in the SPD. Print clearly. Company and contact will also be the Plan Sponsor, Agent for Legal Process, Plan Administrator, and Plan Fiduciary.

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)_______________ FEIN #_______________

2)_______________ FEIN #_______________

3)_______________ FEIN #_______________

Name of Plan Administrator: (Employer unless otherwise listed, shared insurance carrier)

Name_______________

Address_______________

City_______________ State_______________ Zip Code_______________

Phone _______________ Fax _______________

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 will be:

❑ a) a new plan effective date as of (date)_______________

❑ b) Amend and restate an existing Section 125 POP 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)_______________

Employer:____**Group Insurance Wrap SPD - Fax Order Form**

Waiting Period: Employees can participate the ☐ 1st day of employment, or ☐ 1st day following, or ☐ 1st day of month following _______ days of employment. (90 day maximum)

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

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

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.

Statement of Grandfathered Status:
Does your health plan have Grandfathered Status? ☐ Yes ☐ No

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

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

Core Documents Inc.

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

☐ **Deluxe Binder – New Core Group Insurance SPD Wrap Plan Document** **$149.00** ☐

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

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OR

☐ **Basic PDF Option - New Core Group Insurance SPD Wrap** **$99.00** ☐

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: ______________________________
- ❑ Other Insurance: ______________________________
- ❑ Other Insurance: ______________________________
- ❑ Other Insurance: ______________________________
- ❑ Other Insurance: ______________________________

☐ **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** ☐

TOTAL $ TOTAL

Core Documents Inc.

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Employer:____ Group Insurance Wrap SPD - 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:

____

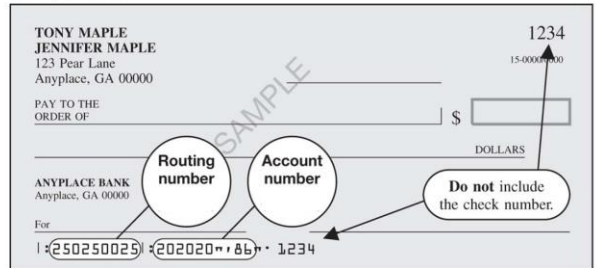
Bank Name: ____

Bank Routing Number: ________________________________

Bank Account Number: ________________________________

Total amount to be charged: $____________

Sample Check



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: ☐ Discover ☐ VISA ☐ MasterCard ☐ American Express

Card Number: __________ __________ __________ __________

Expiration Date: _____/_____

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

Security Code

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
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