

## Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Flex 105 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 Plan Documents

(Owner/controller, document signer; exactly as it should appear in the plan document.)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Company \_\_\_\_\_  
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) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

### Plan Administrator

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

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

**Protected Health Information (PHI) Designee:** \_\_\_\_\_

### Effective Date

- A new plan with an effective date of \_\_\_\_\_  
 Amend and restate an existing Section 105 HRA 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 can participate the  1<sup>st</sup> day of employment, or  1<sup>st</sup> day following, or  1<sup>st</sup> day of month following \_\_\_\_\_ days of employment.

**Eligibility Requirements:** All employees who work \_\_\_\_\_ or more hours per week.

**Please tell us how you found us** Search Engine Agent Google Ad Other \_\_\_\_\_

Employer: \_\_\_\_\_

A Flex 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.

**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

Notes

## Flex105 1-Person HRA Plan Document Package Options

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



**Deluxe Binder – Flex 105 1-Person HRA Plan Document Package** \_\_\_\_\_

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 - Flex 105 1-Person HRA Plan Document Package** \_\_\_\_\_

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** \_\_\_\_\_

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** \_\_\_\_\_

**2nd Year Update - discounted 23% when added to new document order** \_\_\_\_\_

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 1-Person HRA plan document originally produced by us:*

**Update/Amend Health Reimbursement Arrangement HRA Plan Document** \_\_\_\_\_

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

**TOTAL** \_\_\_\_\_

Employer: \_\_\_\_\_

**If paying by check, please complete the following:**

Name as it appears on check: \_\_\_\_\_

\_\_\_\_\_

Bank Name: \_\_\_\_\_

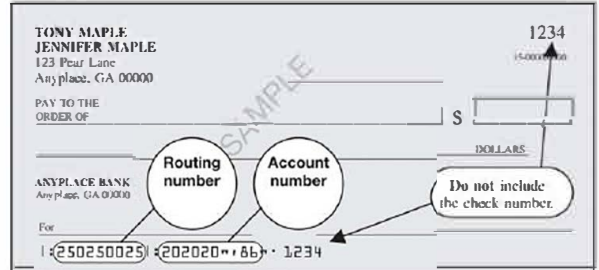
Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Total amount to be charged: \$ \_\_\_\_\_

\_\_\_\_\_  
Signature

**Sample Check**



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

Date: \_\_\_\_\_



**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)

Total amount to be charged: \$ \_\_\_\_\_

**Security Code**



Name as it appears on card: \_\_\_\_\_

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

**Refund Policy:** Purchaser understands that goods and services provided are non-refundable. Orders canceled 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.