Flex COVID-19 | Section 125 Plan Amendment

Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Flex Covid-19 plan amendment 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 ____

COVID 19 Plan Amendment

COVID 19 plan amendment effective date: _________ ___, 2020

COVID 19 mid-year election change limit: ____ 1 per year, or other: ______________________________

Require mid-year elections to Group Health Insurance must improve or increase coverage? Yes No

Require mid-year elections to Group Supplemental Insurance must improve or increase coverage? Yes No

Require mid-year elections to FSAs must be no less than amounts already paid by employer? Yes No

Provide Extended Claims Period option for FSAs to reimburse expenses incurred through December 31, 2020, to

(select all that apply): _____ Health FSA _____ DCAP FSA _____ Limited purpose health FSA _____ N/A

FSA Carryover Options for 2021: $550 unused funds OR 2.5 extra months

Please tell us how you found us: ☐ Search Engine ☐ Agent ☐ Google Ad ☐ Other ___________

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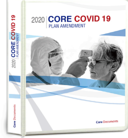
Employer:____

Do you want your Flex COVID-19 plan amendment package in the Deluxe Binder version or the Basic PDF Option?



☐ **Deluxe Binder – New Flex COVID-19 Plan Amendment** ☐

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 Flex COVID-19 Plan Amendment** ☐

PDF Document Processed Quickly and Sent Via E-Mail

Add any additional information for plan amendment preparation here:

Flex COVID-19 | Section 125 Plan Amendment

Employer:____

If paying by check, please complete the following:

Name as it appears on check:

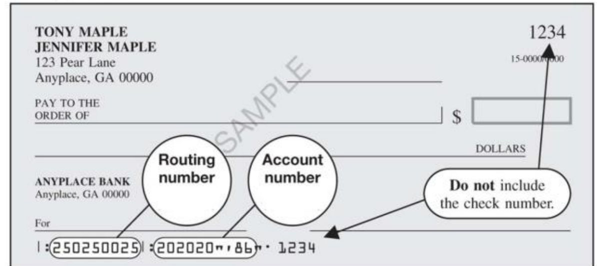
____

Bank Name: ____

Bank Routing Number: ________________________________

Bank Account Number: ________________________________

Total amount to be charged: $____________



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: $____________

Name as it appears on card: ____

X____ Date: ________________
Signature

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.