Flex DCAP | Dependent Care FSA Plan Document

Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Flex DCAP 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.

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_____

DCAP FSA Annual Plan Limit: The IRS limits DCAP FSA plans to $5,000 in employee contributions. Choose the standard $5,000 option or designate a lower employee contribution limit here. ❑ $5,000 **OR** ❑Other_____

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 us: ❑ Search Engine ❑Agent ❑ Google Ad ❑ Other_____

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Employer:_____

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

☐ **Deluxe Binder – New Flex DCAP FSA Plan Document** ☐

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 DCAP FSA Plan Document** ☐

PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the DCAP FSA 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 25% 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 update price.

☐ **Premium Only Plan – pre-tax insurance premium** ☐

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** ☐

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.

☐ **Health FSA to pretax medical expenses - Save 45%** ☐

Save 45% off the normal Health FSA price when added to the DCAP FSA. Health FSA employee
contributions set at $2,750 by the IRS. Choose☐ $2,750 or ☐ Other amount $_____.
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** ☐

☐ **Update/Amend a Health FSA Plan Document** ☐

☐ **Update/Amend a Dependent Care FSA Plan Document** ☐

☐ **Update/Amend any 2 plan combination Document** ☐

☐ **Update/Amend a full 3 plan Cafeteria Document** ☐

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

TOTAL $ TOTAL

Flex DCAP | Dependent Care FSA Plan Document

Employer:_____

If paying by check, please complete the following:

Name as it appears on check:

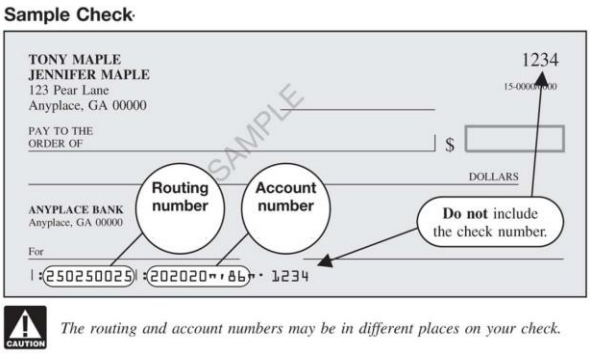
_____

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____



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.