Flex HSA | Tax Free Premium + HSA Savings

Ordering Information Worksheet

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

Benefit Programs to be Offered

☐ Group Health Insurance ☐ Dental Insurance ☐ Vision Care ☐ Group Term Life (Up to $50,000)
☐ Accident Insurance ☐ Cancer Insurance ☐ Other _____

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.

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

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Employer:_____

Do you want your Fkex HSA package in the Deluxe Binder version or the Basic PDF Option?

☐ **Deluxe Binder – New Flex HSA 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 HSA Document** ☐

PDF Document Processed Quickly and Sent Via E-Mail

Optional modules and services (can be added to either of the above options):

☐ **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.

☐ **Health Flexible Spending Account (FSA) Pretax medical expenses** ☐

Save 22% off normal Flex FSA price when added to the Premium Only Plan. Delivered via email unless the Deluxe Binder version is selected (above).

1. Choose the standard limit or designate a lower employee contribution limit here:
   q Standard OR q Other $_____.
2. Please choose option for unused funds at end of year: q $550 Carryover q 2.5 Month Grace Period
3. Name of Protected Health Information (PHI) Designee: _____

☐ **Dependent Care Assistance Plan (FSA) Pretax childcare - Save 22%** ☐

Save 22% off normal Flex DCAP FSA price when added to the Premium Only Plan.
Delivered via email in PDFformat unless the binder option is chosen above.
DCAP employee contributions set at $5000 by the IRS.

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

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Employer:_____

If paying by check, please complete the following:

Name as it appears on check:

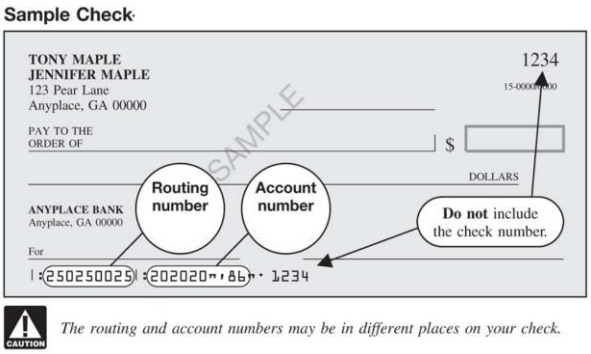
_____

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.