Flex FSA | Health FSA Plan Document

If you have questions while completing this worksheet, please call us at 1-888-755-3373.

Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Flex FSA 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. When the form is complete, go to www.corefsa.com to order your package online.

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_____

Health FSA Annual Plan Limit: The IRS limits Health FSA plans to $2,750 in employee contributions. Choose the standard $2,750 option or designate a lower employee contribution limit here. ❑ $2,750 **OR** ❑Other_____
Choose year end carryover provision for unused funds: ❑ $500 Carryover, **OR** ❑ 2.5 Month Grace Period
Protected Health Information (PHI) Designee Name:_____

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 Health FSA 'Deluxe Binder Option' or the 'Basic PDF Option':

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

PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the Health 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.

☐ **Dependent Care Assistance Plan (FSA) Pretax childcare - Save 45%** ☐

Save 45% off normal DCAP FSA price when added to the Health FSA. DCAP employee contributions set by the IRS. Delivered via email in PDF format unless the binder option is chosen above.

Update and Amend a plan document originally produced by us:

☐ **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_____

Flex FSA | Health FSA Plan Document

If you have questions while completing this worksheet, please call us at 1-888-755-3373.

Employer:_____

If paying by check, please complete the following:

Name as it appears on check:

_____

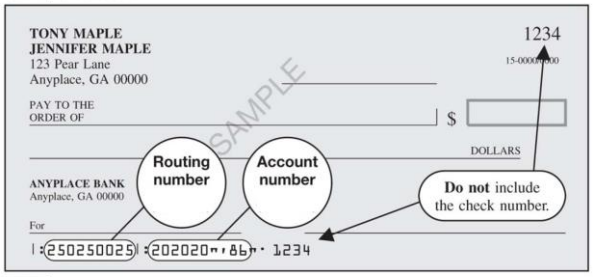
Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____

Sample Check



CAUTION *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)

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 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.