Flex QSEHRA

Qualified Small Employer HRA Plan

Ordering Information Worksheet

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

Please name the person who will be responsible for the proper handling of medical information protected under HIPAA law: _____

Effective Date

☐ A new plan with an effective date of _____.

☐ Amend and restate an existing plan document 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:_____

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.

Choose your QSEHRA Options:

Annual benefit limit: q Maximum Allowed ($5,250 Individual; $10,600 Family for 2020) **OR** q Other$_____

Will your HRA make the funds available: q Monthly **OR** q Lump Sum

Will your HRA Plan reimburse for: q Premium only **OR** q Premium and/or all allowed IRS 213(d) medical, dental, and vision expenses

Will your HRA carry over unused funds at the end of the plan year? q Yes **OR** q No

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Please enter additional plan design notes below

Please give as much detail as possible an exactly how you want your custom HRA plan to be designed. A benefit specialist will contact you regarding specific questions, plan design issues, or additional information as needed. Also add any special notes regarding a dba name, delivery address (physical and email), eligibility requirements, etc.

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

○ **Deluxe Binder – QSE-Health Reimbursement Arrangement 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 - QSE-Health Reimbursement Arrangement Plan Document**

PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the QSEHRA 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.

Update and Amend an QSEHRA plan document originally produced by us:

☐ **Update/Amend IC-Health Reimbursement Arrangement HRA Plan Document**

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

TOTAL _____

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Employer:_____

If paying by check, please complete the following:

Name as it appears on check:

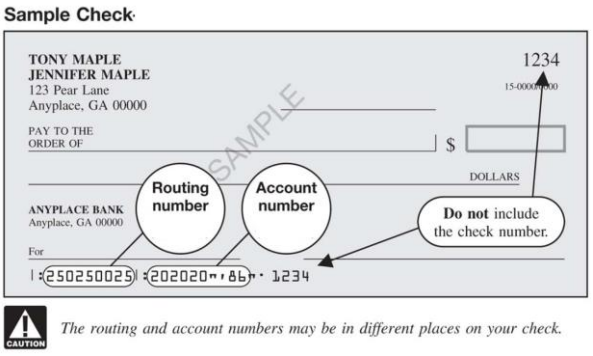
_____

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.