Flex SPD | Wrap SPD Plan Document

Ordering Information Worksheet

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

(Owner/controller, document signer; exactly as it should appear in the SPD. Company and contact will also be the Plan Sponsor, Agent for Legal Process, Plan Administrator, and Plan Fiduciary.)

First Name ________________________ Last Name ________________________
Company Name ________________________
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) ________________________ FEIN#__________________
2) ________________________ FEIN#__________________
3) ________________________ FEIN#__________________

Plan Administrator

☐ Employer (use 'employer' information, above) ☐ Other (provide information below)

First Name ________________________ Last Name ________________________
Company ________________________
Address ________________________
City ________________________ State __________ Zip Code __________
Phone __________________ Email ________________________

Name of Fully Insured Plan Insurance Carrier(s): (i.e. Blue Cross Blue Shield or Aetna Health Insurance)

☐ Health Insurance Carrier 1: ________________________
☐ Health Insurance Carrier 2:________________________
☐ Health Insurance Carrier 3: ________________________

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.

Funding Mechanism: ☐Employer General Assets ☐Employee Contributions Trust Account
☐Union or Collective Bargained Agreement ☐Other Employee Organization

Assigned Plan Number: ☐501 ☐502 ☐503 ☐ ______ Plan identification for reporting purposes.

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Documenting Method for Identifying Full-Time Employees: (Search - IRS Notice 2012-58 for information)

☐**Monthly Measurement Period** ☐**Look Back Period Alternative Method** Effective in 2014, the health care reform law imposes penalties on employers with **at least 50 full-time equivalent employees** if they do not offer health coverage to their employees or if they offer health coverage to their employees that is not "affordable" or does not provide "minimum value" and certain other requirements are met. The Flex Wrap SPD defaults to the standard *Monthly Measurement Period* where every employee working 31 or more hours last month are full-time. The *Look Back Period* alternative method is for groups with employees who work a flexible schedule (or as needed) and there is no way to actually determine if they will be full-time (for purposes of the ACA fines) or part time (30 hours or less). The *Look Back Method* allows for a Safe Harbor period of time, determined by the employer, of not less than 3 months, and not more than 12 months for identifying full- time or part-time status.

Statement of Grandfathered Status: Does your health plan have Grandfathered Status? ☐Yes ☐No

Notice of Patient Protections and Selection of Providers:

If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

Does your health insurance require the designation of a Primary Care Provider: ☐Yes ☐No

Notes: Please include any additional information you believe is relevant to your Plan(s) here.

____

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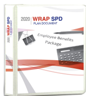
Choose either the 'Deluxe Binder Option' or the 'Basic PDF Option':



☐ **Deluxe Binder – New Flex Group Insurance SPD Wrap Plan Document**
In email PDF version processed ASAP, AND Printed in 3-ring binder, with tabbed index, shipped via Priority Mail.

OR

☐ **Basic PDF Option - New Flex Group Insurance SPD Wrap**
PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the SPD Wrap Deluxe Binder or the Basic PDF Option:

☐ **Supplemental/Ancillary Insurance SPD Module**
Include supplemental/ancillary benefit insurance plans such as dental, vision, critical Illness plans, hospital indemnity, STD, LTD, life etc.

List the Supplemental Insurance Carriers and Benefit Plan Name:

- ❑ Dental Insurance: ____
- ❑ Vision Insurance: ____
- ❑ Group Term Life Insurance: ______________________________________
- ❑ Accidental Death Dismemberment Insurance: __________________________
- ❑ Short Term Disability Illness Insurance: ______________________________
- ❑ Long Term Disability Illness Insurance: ______________________________
- ❑ Accident Insurance: ____
- ❑ Critical Illness Insurance: _______________________________________
- ❑ Cancer Insurance: ____
- ❑ Intensive Care Insurance: _______________________________________
- ❑ Life Insurance: ____
- ❑ Other Insurance: ____
- ❑ Other Insurance: ____
- ❑ Other Insurance: ____
- ❑ Other Insurance: ____

☐ **Plan Document CD Mailed - in addition to PDF email and/or mailed binder**
Have a safe backup copy of your plan document on CD. Documents in PDF; forms in MS Word.

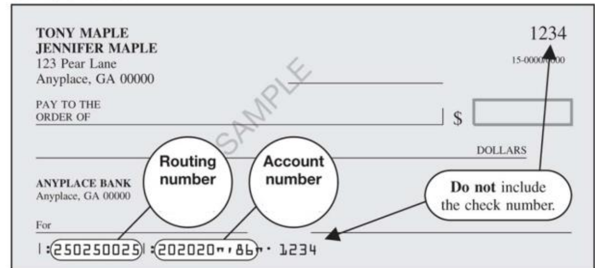
☐ **Rush Order - Your order automatically queued for immediate processing**

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.