Core HSA | Tax Free Premium + HSA Savings

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 Core 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.

When the form is complete, go to www.corefsa.com to order 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 _____ 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 Core Documents: ☐ Search Engine ☐ Agent ☐ Google Ad ☐ Other _____

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Employer:_____

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

☐ **Deluxe Binder – New Core HSA Plan Document** **$229.00** ☐

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 Core HSA Document** **$179.00** ☐

PDF Document Processed Quickly and Sent Via E-Mail

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

☐ **Plan Document USB Drive - in addition to PDF email and/or mailed binder** **$25.00** ☐

Documents provided in PDF format only. Forms in MS Word format.
Always have a safe backup copy of your plan document on USB drive.

☐ **Rush Order - Your order automatically queued for immediate processing** **$25.00** ☐

☐ **2nd Year Update - discounted 25% when added to new document order** **$100.00** ☐

This option entitles you to one plan document amendment in the first 24 months. Save 22% off the normal $129.00 update price.

☐ **Health Flexible Spending Account (FSA) Pretax medical expenses** - Save 33% **$100.00** ☐

Save 33% off normal $149 FSA price when added to the Premium Only Plan. Delivered via email unless the Deluxe Binder version is selected (above).

1. Choose the standard $3,300 limit or designate a lower employee contribution limit here:
   q $3,300 OR q Other $_____.
2. Please choose option for unused funds at end of year: q$660 Carryover q 2.5 Month Grace Period
3. Name of Protected Health Information (PHI) Designee: _____

☐ **Dependent Care Assistance Plan (FSA) Pretax childcare** - Save 33% **$100.00** ☐

Save 33% off normal $149 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** **$129.00** ☐

☐ **Update/Amend a Health FSA Plan Document** **$129.00** ☐

☐ **Update/Amend a Dependent Care FSA Plan Document** **$129.00** ☐

☐ **Update/Amend any 2 plan combination Document** **$259.00** ☐

☐ **Update/Amend a full 3 plan Cafeteria Document** **$299.00** ☐

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

TOTAL $ TOTAL

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Invoice me via email, please complete the following:

Company Name: _____ **Contact:** _____

Email Address for Invoice: _____

If paying by check, please complete the following:

Your order can be processed with the following checking account information and authorization.

Name as it appears on the check:

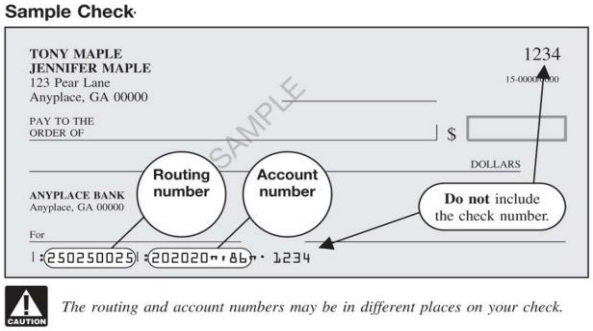
_____

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 Number: _____

Expiration Date: ____ /____

Total amount to be charged: $_____

Name as it appears on card: _____

X_____ Date: _____
Signature

Refund Policy: Purchaser understands that goods and services provided by Core Documents, Inc. 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.

Please sign and fax completed form to (941)795-4802. Attach additional pages of plan design information if needed.

Mail: Core Documents, Inc. P.O. Box 14538, Bradenton, FL 34280
Scan and Email: CoreService@CoreDocuments.com
Toll Free Voice: 888-755-3373 Fax: 941-795-4802