



POP / WRAP PLAN DOCUMENT DATA GATHERING FORM

Name of Organization: _____
(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Employer ID No: _____ Date Incorporated/Organized: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address: _____ Zip: _____

- Organization Type:
- Corporation.
 - Professional Corporation
 - Partnership
 - Government Agency
 - Other _____
 - Sub-chapter "S" Corporation
 - Professional Association
 - Sole Proprietorship
 - LLC Limited Liability Company

The Employer/Organization entity is operating pursuant to the laws of the State of _____.

The Employer/Organization underline insurance plans are operating pursuant to the laws of the State of _____.

Principal Business Activity Code: _____

Does this employer file a 5500 for welfare benefits? _____ Yes _____ No

Are there any other participating employers, if so, please list names and EINs below:

PLAN ELECTIONS

Plan No.: 501 _____ Plan Name: _____

Plan Begin Date: ____/____/____ Plan End Date: ____/____/____

Plan Effective Date: ____/____/____ First Year Effective Date: ____/____/____

ELIGIBILITY REQUIREMENTS

The default for all benefits will be set @ 30 hours unless otherwise notified. Also, the plan waiting periods will be used for all insurance coverage and classes of employees unless otherwise notified.

A. The following class of employees is eligible to participate:

- All
- Salaried Employees Only
- Hourly Employees Only
- Other _____

Tax penalties may be imposed if the Plan contains eligibility requirements that have the effect of favoring highly compensated employees. Consult your tax advisor before limiting participation in the Plan.

B. The following employees are excluded from participation:

- No exclusions.
- Part-time employees normally expected to work less than _____ hours a week.
- Employees under the age of _____.
- Union employees (unless the bargaining agreement provides for coverage).
- Non-resident aliens.
- Other: _____

C. The service period employees must complete before being eligible to participate is as follows:

For the plan year, any one employed on the Plan Effective Date and for subsequent Plan Years

- As of date of hire.
- Number of days after date of hire: _____
- Number of months after date of hire: _____

D. Once the employees are eligible, they can begin participating in the plan:

- Date employee becomes eligible.
- First day of pay period following the date employee becomes eligible.
- First day of month following the date employee becomes eligible.
- First day of quarter following the date employee becomes eligible.
- First day of Plan Year following the date employee becomes eligible.

E. Is the employer subject to pay or play under the ACA law? _____ Yes _____ No

F. On average how many total employees work for this employer during the year? _____

G. Which Employee are generally eligible to participate:

- Spouse
- Dependent/Child
- Domestic Partner
- Other

BENEFIT COORDINATOR

The Benefit Coordinator is the individual at the Employer to whom Employees should direct communications and inquiries.

Name: _____

Title: _____

Company Name: _____

Address: _____

City _____ State: _____ Zip: _____

Telephone _____ Alternate Phone: _____

e-mail _____ Website: _____

LEGAL ACCEPTANCE

Name: _____

Title: _____

Company Name: _____

Address: _____

City _____ State: _____ Zip: _____

Telephone _____ Alternate Phone: _____

e-mail _____ Website: _____

Other

Please list any additional State laws that you would like added to this document. This wrap document is meant to cover your ERISA Federal law procedures..

FEEs

The following fees will be charged:

- Annual fee + POP: \$200