Core Documents Inc.

If you need help completing this application call 1-888-755-3373

CoreSPD.COM

Group Insurance Wrap SPD Fax Order Form

Please print clearly

Purchaser Information (Person buying document for Employer listed below, i.e. Agent, CPA, TPA, agent, etc.)
First Name_____ Last Name_____
Company _____
Address_____
City_____ State_____ Zip Code_____
Phone _____ Fax _____
Email_____
Email/Ship Document to: ❑Purchaser ❑Employer

Employer Information for SPD – Exactly as it should appear in the SPD. Print clearly. Company and contact will also be the Plan Sponsor, Agent for Legal Process, Plan Administrator, and Plan Fiduciary.

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)_____ FEIN #_____
2)_____ FEIN #_____
3)_____ FEIN #_____

Name of Plan Administrator: (Employer unless otherwise listed, shared insurance carrier)
Name_____
Address_____
City_____ State_____ Zip Code_____
Phone _____ Fax _____

Name of Insurance Carrier(s) and Plan(s): (i.e. Blue Cross Blue Shield or Aetna Health Insurance)
❑ Health Insurance Carrier: _____

Effective Date will be:
The insurance plan effective date will be (date)_____

Plan Year - will be:
A 12 consecutive month period beginning (date)_____ (ex. Jan 1) 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. (90 day maximum)

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 ❑ ____ See IRS Publication 1004 for explanation of Plan Numbers

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Employer:_____**Group Insurance SPD Wrap - Fax Order Form**

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

☐ **Deluxe Binder – New Core Group Insurance SPD Wrap Plan Document** **$149.00** ☐

In email PDF version processed ASAP, AND Printed in 3-ring binder, with tabbed index, shipped via Priority Mail.

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OR

☐ **Basic PDF Option - New Core Group Insurance SPD Wrap** **$99.00** ☐

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 -** **$30.00** ☐

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** **$25.00** ☐

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** **$25.00** ☐

TOTAL $ TOTAL

Notes:_____
_____
_____
_____
_____

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Employer:_____**Group Insurance SPD Wrap - Fax Order Form**

If paying by check, please complete the following:

Your order can be processed with a copy of the original check attached to the order made out to Core Documents with amount to be charged, **OR** simply provide the following information and authorization.

Name as it appears on check:

_____

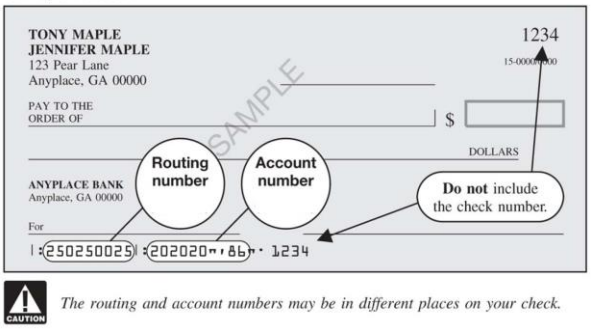
Bank Name: _____

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: ❒Discover ❒VISA ❒MasterCard ❒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 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
Office: 501 Village Green Parkway, Ste. 22, Bradenton, FL 34209
Scan and Email: CoreService@CoreDocuments.com
Toll Free Voice: 888-755-3373 Fax: 941-795-4802