



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

**One-Person Section 105 HRA - Fax Order Form**



Please print clearly

**Purchaser Information** (Person buying document for Employer listed below, i.e. Agent, CPA, payroll co., etc.)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Email \_\_\_\_\_  
 Ship Document to:  Purchaser  Employer

**Employer Information for Plan Documents – Exactly as it should appear in the plan document. Print clearly.**

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) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_

**Name of Plan Administrator** (Employer unless otherwise listed):

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax: \_\_\_\_\_

**Protected Health Information (PHI) Designee:** \_\_\_\_\_

**Effective Date will be:**

a) a new plan effective date as of (date) \_\_\_\_\_  
 b) Amend and restate an existing Section 105 HRA plan as of (new date for this updated plan): \_\_\_\_\_  
 If this is an amended and restated plan, state the (old) original effective date: \_\_\_\_\_

**Plan Year - The first plan year will be:**

a) a 12 consecutive month period beginning (date) \_\_\_\_\_ and ending (date) \_\_\_\_\_  
 b) a short plan year beginning (date) \_\_\_\_\_ and ending (date) \_\_\_\_\_

**Waiting Period:** Employees can participate the  1<sup>st</sup> day of employment, or  1<sup>st</sup> day following, or  1<sup>st</sup> day of 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 \_\_\_\_\_



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

**Employer:** \_\_\_\_\_ **Section 105 HRA - Fax Order Form**

A Core 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. Attach additional design criteria or notes to this order form if necessary.

**Comprehensive Plan Questions:**

Will your HRA plan have an annual benefit limit?  Yes **OR**  No If yes designate the annual limit: \$ \_\_\_\_\_

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

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

Will your HRA reimburse all medical, dental, vision, and premium expenses currently allowed by IRS 213(d)?  Yes **OR**  No

**NOTES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Choose either the Section 105 HRA 'Deluxe Binder Option' or the 'Basic PDF Option':**



**Deluxe Binder – New 1-person Section 105 HRA Plan Document** \_\_\_\_\_ **\$199.00**   
 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 1-person Section 105 HRA Plan Document** \_\_\_\_\_ **\$149.00**   
 PDF Document Processed Quickly and Sent Via E-Mail

**Options that can be added to the Section 105 HRA Deluxe Binder or the Basic PDF Option:**

**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**

**2nd Year Update - discounted 23% when added to new document order** \_\_\_\_\_ **\$99.00**   
 This option entitles you to one plan document amendment in the first 24 months. Save 23% off the normal \$129.00 update price.

**Update and Amend a HRA plan document originally produced by Core Documents:**

**Update/Amend Health Reimbursement Arrangement HRA Plan Document** \_\_\_\_\_ **\$129.00**   
 All Updated/Amended documents delivered via email in PDF format.

**TOTAL** \_\_\_\_\_ **\$ TOTAL**



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

Employer: \_\_\_\_\_ **Section 105 HRA - 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: \_\_\_\_\_

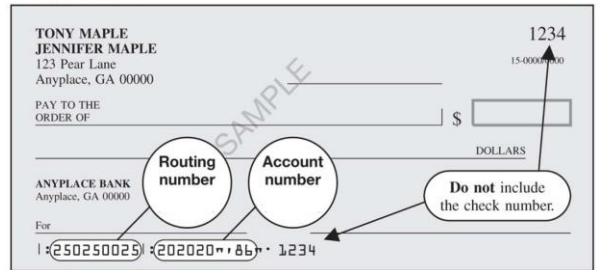
Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Total amount to be charged: \$ \_\_\_\_\_

\_\_\_\_\_  
Signature

**Sample Check**



**CAUTION** The routing and account numbers may be in different places on your check.

Date: \_\_\_\_\_



**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)

Total amount to be charged: \$ \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature

**Security Code**



**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. 221, Bradenton, FL 34209  
Scan and Email: [CoreService@CoreDocuments.info](mailto:CoreService@CoreDocuments.info)  
Toll Free Voice: 888-755-3373 Fax: 941-795-4802