Application & Installation Checklist

Employer Information

Employer's Legal Name			**Federal EIN**
Name of ☐ **Plan** or ☐ **DBA**		**Plan Number (5500)** (For ERISA Form 5500 purposes, e.g., 501, 502, 503, etc.)	
# of Participants	**Total # of EEs**	**Type of Business**	☐ C Corp ☐ S Corp ☐ LLC ☐ Government ☐ Other _____
Employer Contact			**Title**
E-mail			**Phone**
Mailing Address Street		Suite/Bldg City	State Zip
Physical Address ☐ **Same** Street		Suite/Bldg City	State Zip
Plan Year Dates[1] Start – End		☐ **Last Wrap Dated** **OR** ☐ **Original Plan Year** (1st year employer started offering welfare benefits to its employees)	Start – End
Any Other Named Fiduciary (Trustee)			**Phone**
Mailing Address Street		Suite/Bldg City	State Zip
Agent for Svc of Legal Process (The person or company designated to accept **service** of **process** on behalf of the company.)			**Phone**
Mailing Address Street		Suite/Bldg City	State Zip
COBRA Administrator			**Phone**
Mailing Address Street		Suite/Bldg City	State Zip

Broker Information

Agency Name			**Agency Contact**
E-mail			**Phone**
Mailing Address Street		Suite/Bldg City	State Zip
Physical Address ☐ **Same** Street		Suite/Bldg City	State Zip
Broker Recognition Default is No	Marketplace Notice ☐Yes ☐No	EverWrap Document ☐Yes ☐No	Sample Cover Letter to EE ☐Yes ☐No

Delivery and Billing Instructions

Deliverables Sent to:	☐ **Client Contact** **E-mail:**	☐ **Agent/Consultant** **E-mail:**	☐ **Other:** **E-mail:**
Bil ling Sent to:	☐ **Client Contact** **E-mail:**	☐ **Agent/Consultant** **E-mail:**	☐ **Other:** **E-mail:**

Prepared and Authorized By (Printed Name):

Title:

Signature **Date Signed**

[1] Short Plan Years are allowed only once during any 24 months.

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Marketplace Notice Information

Name of *Lowest-Cost,* Passing Health Plan[2]

Passing Plan is a plan that meets PPACA standards, if applicable. If multiple employee Classes/Health plans, provide name of lowest cost passing plan for each EE class.

Cost to EE / Year $ (Employee Contribution Only)	**Are there any EEs that are not offered a Health Plan?** (i.e. part-time employees) ☐ Yes ☐ No
What contact information should appear on PPACA Notice PAGE 1 ☐ Employer (Default) ☐ Broker	**What contact information should appear on PPACA Notice PAGE 2** ☐ Employer (Default) ☐ Broker

Which of the following benefits are eligible to Pre-Tax?

☐ Group Health Benefits
☐ Dental Benefits
☐ Vision Benefits
☐ Accident
☐ Group Critical Illness
☐ Hospital Indemnity
☐ Cancer
☐ HSA
☐ Other: _____

Miscellaneous Plan Provision (Check all that Apply)

☐ **Retiree Coverage (Rx or Health is provided)** ☐ Yes ☐ No (Default)

☐ **PCP is required for the following welfare plans:**

☐ **Trade Adjust Assist by DOL applies**
☐ Yes ☐ No (Default)
☐ N/A

Include E-Verify Notice ☐ Yes (Default) ☐ No

Include Variable Hours Language ☐ Yes (*please complete chart provided*) ☐ No (Default)

Plan Information

Select ONE (If Multiple Apply – Multiple Docs Needed)

☐ Single Employer Plan
☐ Controlled Group (as defined by ERISA)
☐ Multiple Employer Under "Common Ownership"
☐ MEWA (Multiple Employer Welfare Agreement)
☐ Employee Leasing or PEO
☐ Union or CBA (Collective Bargaining Agreement)

	Carrier	Plan Name	CMS Status
Dates for PRIOR Health Plan Year From: to			☐ Credible ☐ Non-Credible
			☐ Credible ☐ Non-Credible
			☐ Credible ☐ Non-Credible
			☐ Credible ☐ Non-Credible
			☐ Credible ☐ Non-Credible
Dates for CURRENT Health Plan			☐ Credible ☐ Non-Credible
			☐ Credible ☐ Non-Credible
			☐ Credible ☐ Non-Credible
			☐ Credible ☐ Non-Credible

[3]**May Employee retain Rx coverage when eligible for Medicare?** ☐ Yes ☐ No ☐ N/A

[4]**Will Rx coverage coordinate with Medicare?** ☐ Yes ☐ No ☐ N/A

[3] This question usually only applies if retiree medical coverage is offered.
[4] This question usually only applies if retiree medical coverage is offered.

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Instructions for the 'Benefits' Section

- **On the Following pages Be specific-about employee eligibility definitions - verbiage should match contracts & be reflected in the Client's Admin practices. If multiple EE classes exist – provide a separate sheet for each benefit/class.**
- **Ensure you have included all benefits required to be disclosed. Please refer to the Labor Management Act &/or ERISA to determine if you offer other ERISA covered benefits (Transportation, 2 Adoption, Pre-Paid Legal, etc).**
- **We are required to provide the contact address for all entities that administer claims for benefit plans – all insured and Third Party Administrators of self-insured plans such as FSA, COBRA, HRA, or any other plan administered. This information will be provided in the document.**

☐ Group Health ☐ Retiree Medical Supplemental

Carrier		**Plan Name**	
Benefits Funded By CHOOSE ONE		**Plan-Claims Services by** CHOOSE ONE	
Who Contributes to the Plan? CHOOSE ONE			
Employee Eligibility	**Hours worked/ Week:**	**Spouse Eligibility Includes**	☐ Domestic Partners
Probationary Period – Benefits Begin		**Benefits End** CHOOSE ONE	
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address Street	Suite/Bldg City	State	Zip

Additional Comments (Include Plan Name):

CHOOSE ONE BELOW:

We Do Not Offer Spousal Health Plan Coverage
We Offer Spousal Coverage, Including Domestic Partner
We Offer Spousal Coverage, *Excluding* Domestic Partner

☐ Dental

Carrier		**Plan Name**	
Benefits Funded By CHOOSE ONE		**Plan-Claims Services by** CHOOSE ONE	
Who Contributes to the Plan? CHOOSE ONE			
Employee Eligibility	**Hours worked/ Week:**	**Spouse Eligibility Includes**	☐ Domestic Partners
Probationary Period – Benefits Begin		**Benefits End** CHOOSE ONE	
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address Street	Suite/Bldg City	State	Zip

Additional Comments (Include Plan Name):

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☐ Vision

Carrier		**Plan Name**	
Benefits Funded By	CHOOSE ONE	**Plan-Claims Services by**	CHOOSE ONE
Who Contributes to the Plan?	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**	**Spouse Eligibility Includes**	☐ Domestic Partners
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE

**If Claims Services Provided by party other than the Employer – Please Complete Below*

Name	**Phone**
Claims Address Street Suite/Bldg City State Zip	

Additional Comments (Include Plan Name):

☐ Base Life ☐ AD&D ☐ Supp Life ☐ Supp AD&D

Carrier		**Plan Name**	
Benefits Funded By	CHOOSE ONE	**Plan-Claims Services by**	CHOOSE ONE
Who Contributes to the Basic Life & AD&D Plan?	CHOOSE ONE		
Who Contributes to the Supplemental Life & AD&D Plan?	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE

**If Claims Services Provided by party other than the Employer – Please Complete Below*

Name	**Phone**
Claims Address Street Suite/Bldg City State Zip	

Additional Comments (Include Plan Name):

☐ Long Term Disability Benefits

Carrier		**Plan Name**	
Benefits Funded By	CHOOSE ONE	**Plan-Claims Services by**	CHOOSE ONE
Who Contributes to the Plan?	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE

**If Claims Services Provided by party other than the Employer – Please Complete Below*

Name	**Phone**
Claims Address Street Suite/Bldg City State Zip	

Additional Comments (Include Plan Name):

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☐ Short Term Disability Benefits

Carrier		**Plan Name**	
Benefits Funded By	CHOOSE ONE	**Plan-Claims Services by**	CHOOSE ONE
Who Contributes to the Plan?	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address	Street Suite/Bldg City State Zip		

Additional Comments (Include Plan Name):

☐ Healthcare Flexible Spending ☐ Dependent Care Flex

Carrier		**Plan Name**	
Benefits Funded By	Employer	**Plan-Claims Services by**	CHOOSE ONE
Who Contributes to the Plan?	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address	Street Suite/Bldg City State Zip		

Additional Comments (Include Plan Name):

☐ Health Savings Account

Carrier		**Plan Name**	
Who Contributes to the Plan?	CHOOSE ONE	**Plan-Claims Services by**	CHOOSE ONE
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin			
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address	Street Suite/Bldg City State Zip		

Additional Comments (Include Plan Name):

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☐ Health Reimbursement Arrangement

Carrier		**Plan Name**	
Plan-Claims Services by	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address	Street Suite/Bldg City State Zip		

Additional Comments (Include Plan Name):

☐ Other – Define:

Carrier		**Plan Name**	
Benefits Funded By	CHOOSE ONE	**Plan-Claims Services by**	CHOOSE ONE
Who Contributes to the Plan?	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address	Street Suite/Bldg City State Zip		

Additional Comments (Include Plan Name):

☐ Other – Define:

Carrier		**Plan Name**	
Benefits Funded By	CHOOSE ONE	**Plan-Claims Services by**	CHOOSE ONE
Who Contributes to the Plan?	CHOOSE ONE		
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End**	CHOOSE ONE
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address	Street Suite/Bldg City State Zip		

Additional Comments (Include Plan Name):

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☐ Other – Define:			
Carrier		**Plan Name**	
Benefits Funded By CHOOSE ONE		**Plan-Claims Services by** CHOOSE ONE	
Who Contributes to the Plan? CHOOSE ONE			
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End** CHOOSE ONE	
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address Street	Suite/Bldg	City	State Zip

☐ Other – Define:			
Carrier		**Plan Name**	
Benefits Funded By CHOOSE ONE		**Plan-Claims Services by** CHOOSE ONE	
Who Contributes to the Plan? CHOOSE ONE			
Employee Eligibility	**Hours worked/ Week:**		
Probationary Period – Benefits Begin		**Benefits End** CHOOSE ONE	
**If Claims Services Provided by party other than the Employer – Please Complete Below*			
Name		**Phone**	
Claims Address Street	Suite/Bldg	City	State Zip

Remember to provide:

☐ Summary Benefit Coverage (SBCs) ☐ Other Benefit Summaries ☐ Employer Logo (File: JPEG, BMP, PNG)

Admin America, Inc.'s provision of the EverWrap™ ERISA Documentation Service may be completed with the assistance of an unaffiliated third party.

Any such third party shall be subject to written non-disclosure and non-compete agreements. Copies of these executed agreements are available upon request made to Admin America at any time by the client or their professional advisor/agent.

Please complete and return this *Appplication*, *Medical SBCs*, *Summary of Benefits* and a file with the *Employer Logo*. Please do not hesitate to call with any questions in completing the Application. Thank you!