Please send this form to:
1200 River Ave, Suite 10E, Lakewood, NJ 08701
Fax: 732-377-0390
E-Mail: Info@flexfacts.com

WRAP Document Client Application

Company Information

Employer's Legal Name: ____________________

Address: ____________________
Street Address *Suite/ Unit #*

____
City *State* *ZIP Code*

Phone: ____________ Type of Legal Entity: ____________

HR Contact Name: ____________ E-mail Address: ____________

HIPAA Authorized Contact: ____________ Title: ____________

Phone Number: ____________ Federal Tax ID Number: ____________

Please list any affiliated employers adopting this plan: ____________

Agent Name: ____________ Company: ____________

Phone Number: ____________ E-mail Address: ____________

Plan Information

Plan Name (as listed on Form 5500): ____________ Plan Number: ________

Is this Plan **New** or **Reinstatement/ Amendment**? New Amendment

Is this entity subject to Section 1557 of the ACA? Yes No

Required Working Hours Per Week: ________ Are Retirees Eligible? Yes No

Plan Year Start: ________ Plan Year End: ________ Short Plan Year? Yes No

Do you have variable hour employees? Yes No Date of Eligibility: ________

Are the following employees eligible (check off all that apply): Salaried Employees Leased Employees

Hourly Employees Retiree Union Non-Resident Aliens Variable Hour Employees Other: ________

Waiting Period (days): ________ Eligibility Requirements:

Benefit Plan 1

Plan Type Offered: ____________

Policy Identification Number: ____________ Carrier Name: ____________

Effective Date of Benefit: ____________ Is Benefit an exception to PPACA? Yes No

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Benefit Plan 2

Plan Type Offered: ______________________________

Policy Identification Number: ______________ Carrier Name: ______________________________

Effective Date of Benefit: ______________ Is Benefit an exception to PPACA? Yes No

Benefit Plan 3

Plan Type Offered: ______________________________

Policy Identification Number: ______________ Carrier Name: ______________________________

Effective Date of Benefit: ______________ Is Benefit an exception to PPACA? Yes No

Benefit Plan 4

Plan Type Offered: ______________________________

Policy Identification Number: ______________ Carrier Name: ______________________________

Effective Date of Benefit: ______________ Is Benefit an exception to PPACA? Yes No

Benefit Contribution

How are Employee Contributions Made? Payroll Contributions Other: ______________________

Contribution Source (check all that apply): Employee Employer

Include Subrogation provision in this document (applicable for self-insured plans only)? Yes No

Include FMLA provision in this document? Yes No

Include COBRA provision in this document? Yes No

Do you have any Medicare Eligible participants (active, retired, COBRA, or Disabled), or any of their dependents, enrolled in your group health plan or prescription drug plan? Yes No

If your Group Health Plan or Rx Benefit is "Creditable" with Medicare, which notices are to be included in the document? Yes No

Include HIPAA provisions in this document? Yes No

Are the benefits included in this plan self-funded or fully-insured?

Employer Signature

Employer Signature: ______________________________ Date: ______________________