MoneyWise Solutions

WRAP DOCUMENT INTAKE QUESTIONS

COMPANY INFORMATION

Legal Company Name:				
Federal Tax ID Number:				
DBA (If Applicable):				
Company Headquarters Address:				
Type of Company:				
Number of Eligible Employees:	Full-Time:		Part-Time:	

AFFILIATED COMPANIES

Only complete this section if the Plan Sponsor has any affiliated companies. Companies with common ownership or shared control may be considered affiliated, even if they have separate EINs. Employees of these affiliated entities may still be eligible to participate in the same benefits plan. Please indicate any such relationships.

Are there any affiliate companies of the plan sponsor?: ☐ Yes ☐ No

Do employees of an entity with a different EIN than the employer's EIN participate in this Plan?:
☐ Yes ☐ No

If yes to, please provide the following:

Affiliate Name:		Affiliate Company Type:	
Affiliate EIN:		Affiliate Address:	

Are employees covered under this Plan only if the affiliates formally adopt this Plan by signature?:
☐ Yes ☐ No

COMPANY DIVISIONS

**Only complete this section if you have divisions or locations that have different types of benefits offered, different eligible requirements, or if you select COBRA, FMLA Services.*

Division Name	**Division EIN** (if applicable)	**Division Address**	**# of Employees at Division** (FMLA Only)	**Does this Division Require Any of the Following:**
			_____	☐ Divisional Reporting ☐ Divisional Banking
			_____	☐ Divisional Reporting ☐ Divisional Banking
			_____	☐ Divisional Reporting ☐ Divisional Banking
			_____	☐ Divisional Reporting ☐ Divisional Banking

COMPANY CONTACTS

Please list all applicable company contacts according to the following criteria:

- ***Primary Contact****: Responsible for overall program and plan authorization. This person will receive all general communications and important notices from MoneyWise Solutions.*
- ***Monthly Billing Contact****: Designated to receive the monthly invoice from MoneyWise Solutions.*
- ***Remittance Contact*** *(For COBRA & FMLA Administration Only): Responsible for receiving communications regarding remittance payments due to the company.*
- ***Eligibility Contact****: Responsible for receiving all information related to employee and participant enrollment and eligibility.*
- ***Technical Contact****:Responsible for communications regarding the setup of any electronic file transmissions.*

Full Name	Email	Phone	Division *(If Applicable)*	Portal Access *(If Applicable)*	Contact Type *(Check all that apply)*
				☐ Yes ☐ No	☐ Primary Contact ☐ Monthly Billing ☐ Remittance (COBRA & FMLA Only) ☐ Eligibility ☐ Technical
				☐ Yes ☐ No	☐ Primary Contact ☐ Monthly Billing ☐ Remittance (COBRA & FMLA Only) ☐ Eligibility ☐ Technical
				☐ Yes ☐ No	☐ Primary Contact ☐ Monthly Billing ☐ Remittance (COBRA & FMLA Only) ☐ Eligibility ☐ Technical
				☐ Yes ☐ No	☐ Primary Contact ☐ Monthly Billing ☐ Remittance (COBRA & FMLA Only) ☐ Eligibility ☐ Technical

				☐ Yes ☐ No	☐ Primary Contact ☐ Monthly Billing ☐ Remittance (COBRA & FMLA Only) ☐ Eligibility ☐ Technical
				☐ Yes ☐ No	☐ Primary Contact ☐ Monthly Billing ☐ Remittance (COBRA & FMLA Only) ☐ Eligibility ☐ Technical

BROKER OR AGENCY CONTACT	
Agency Name:	
Broker Full Name:	
Email:	
Phone:	
Broker Portal Access:	☐ Yes ☐ No

WRAP DOCUMENT

PLAN BENEFIT INFORMATION

Please complete the chart below for all benefits to be included in this Wrap Document.

Carrier Name: *Enter the name of the carrier providing the coverage of this benefit.*

Policy Identifying Number: *Enter the policy number exactly as it appears on the policy information, or the certificate of coverage provided by the carrier of the benefit.*

Benefit Type: *Generic name of this benefit (e.g., Fully Insured Health Plan has a benefit type of "Medical," Short-Term Disability has a benefit type of "Disability," etc.).*

PPACA Compliance: *Under the Patient Protection and Affordable Care Act of 2010 ("PPACA"), a "group health plan" must provide minimum coverage to all eligible individuals. There are certain benefits that are "excepted" or not subject to certain requirements that otherwise apply to group health plans:*

1. Benefits that are generally not considered health coverage (such as auto insurance, accidental death and dismemberment benefits or workers compensation coverage);
2. Limited excepted benefits which are excepted based on meeting certain requirements (such as limited scope vision or dental coverage, long term care benefits or nursing home care);
3. Non-coordinated excepted benefits (such as cancer coverage or fixed indemnity plans); and
4. Supplemental excepted benefits that are offered as a separate policy and supplemental to Medicare, Armed Forces coverage or (in very limited circumstances) group health coverage (such as a Medicare Supplemental Plan).

Effective Date: *Enter the effective date on which the benefit was active for your employees (note: this may be different from the Plan Year effective date for the Plan as a whole).*

Administrator: *The Plan Administrator is the official party responsible for the overall plan under ERISA. This is typically the employer or plan sponsor. They are on the hook legally for making sure the plan complies with the rules, files forms like the 5500, and provides the correct notices to employees. So, in most cases, this is you — the company.*

The Benefit Administrator is usually a third party or vendor you hire to help run parts of the plan — like processing claims, sending COBRA notices, or handling day-to-day tasks. But here's the key: they are not legally responsible for the plan. They support you, but the compliance responsibility stays with the Plan Administrator.

Check Plan to Include	Carrier Name	Policy ID	PPACA Excepted	Effective Date	Administrator (Check)
Health Plan (Fully-Insured)			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Health Plan (Self-Funded)			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Dental			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Vision			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Health Flexible Spending Account (FSA)			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Health Reimbursement Arrangement (HRA)			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Long-Term Disability			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Short-Term Disability (insured)			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin

Short-Term Disability (self-funded)			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Group-Term Life for Employees			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Accidental Death and Dismemberment			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Business Travel Accident Plan			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Employee Assistance Program (EAP)			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
On Site Clinic			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Pharmacy			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Wellness Plan			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin
Other			☐ Yes ☐ No		☐ Plan Admin ☐ Benefit Admin

PLAN ADMINISTRATION INFORMATION

Plan Name:	
Plan Number (501-530):	
Plan Administrator Name (Only if different from Employer):	
Address, City State, Zip:	
COBRA Administrator Name (Only if different from Employer):	
Address, City State, Zip:	
Named Fiduciary (Only if different from Employer):	
Address, City State, Zip:	
Agent for Service of Legal Process (Only if different from Employer):	
Address, City State, Zip:	

PLAN ADMINISTRATION INFORMATION

If you selected Benefit Administrator for any of the benefits listed under Plan Benefit Information above, please specify the benefit administrator here. Otherwise, you can skip this section.

Benefit Administrator:	
Benefit Type:	
Name of Administrator:	
Address, City State, Zip:	
Benefit Type:	

Name of Administrator:	
Address, City State, Zip:	
Benefit Type:	
Name of Administrator:	
Address, City State, Zip:	
Benefit Type:	
Name of Administrator:	
Address, City State, Zip:	
Benefit Type:	
Name of Administrator:	
Address, City State, Zip:	

PLAN INFORMATION

Is this Plan New or a Restatement? ☐ New ☐ Restatement

If this is a brand new plan for your company, please select "New." If you are amending and restating a previous plan, please select "Restatement"

Plan Year Start: _____/_____/_____

The Plan Year Start should be consistent with the plan year for all other group benefits if possible. Do not back date a plan year start.

Plan Year End: _____/_____/_____

The date on which this Plan Year ends - typically the end of the calendar year or the end of the 12th month after the Plan Year Start - with the exception of short plan years.

Original Effective Date (Only if Restatement): _____/_____/_____

Amended and Restated Date (Only if Restatement): _____/_____/_____

Short Plan Year: ☐ Yes ☐ No

Renewal Year Start (only if Short Plan year): _____/_____/_____

Renewal Year End (only if Short Plan year): _____/_____/_____

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

If "YES" to above
Civil Rights Coordinator Name: _____
Civil Rights Coordinator Email: _____
Civil Rights Coordinator Phone: _____
Civil Rights Coordinator TTY Phone: _____

Are claims administration/appeals procedures included in each of the underlying certificates or benefit policies?: ☐ Yes ☐ No

If "NO" to above complete the following with the time limit for each:

Notification timing regarding original claim
Urgent Care (0 - 72 hours): _____
Pre-Service (0 - 15 days): _____
Post-Service (0 - 30 days): _____

Notification timing regarding appeals
Urgent Care (0 - 72 hours): _____
Pre-Service (0 - 15 days): _____
Post-Service (0 - 30 days): _____

EMPLOYEE ELIGIBILITY

Include Employees that work _____ hours or more per week.

The PPACA generally states that, beginning in 2015 or 2016, as applicable, all employees working 30 hours or more per week are eligible for Plan benefits. However, the Plan may allow employees who work fewer than 30 hours per week to be eligible for the Plan. Exceptions may also exist for companies with less than 50 employees or for non-group health plan coverage

Include Retirees: ☐ Yes ☐ No

Exclude the following:

This pertains to the eligibility of the Plan itself and not for the underlying benefits. Select the employee classes that will not be eligible for benefits under the Plan.

Union: ☐ Yes ☐ No
Non-Resident Aliens: ☐ Yes ☐ No
Hourly Employees: ☐ Yes ☐ No
Salaried Employees: ☐ Yes ☐ No
Leased Employees: ☐ Yes ☐ No
Other Employee Class Exclusions: _____

Post-Hire Waiting Periods:

The waiting period for the Health FSA can be up to 3 years. However, the waiting period for the FSA cannot be less than that of the underlying health coverage. For consistency, employers should have the waiting period for the FSA mirror the waiting period for the underlying health insurance plan.

Employee Class	Waiting Period (days)

Entry Into Plan:

This requirement must be satisfied before an employee is eligible for Plan entry. Keep in mind that federal regulation generally prohibits an employee from waiting longer than 90 days before becoming eligible (i.e., after taking into consideration the date the policy of coverage becomes effective).

Please select one of the following:

- ☐ 1st day of the month following date requirements were met
- ☐ 1st Day of Pay period following waiting period
- ☐ Date that conditions of eligibility are met
- ☐ Other (provide a description): _____

Do you have variable hour employees?: ☐ Yes ☐ No

Will you be using the IRS Look-back measurement method to determine employee status?: ☐ Yes ☐ No

If yes to both Variable and Lookback, then please answer the following:

<u>New Employees</u>
Initial Measurement Period (3-12 Months): _____
Administrative Period (1 - 90 Days): _____
Stability Period (6-12 Months): _____

<u>Ongoing Employees</u>
Standard Measurement Period Start Date: _____/_____/_____
Standard Measurement Period Duration (3 - 12 Months): _____
Administrative Period (1 - 90 Days): _____
Stability Period Start Date: _____/_____/_____
Stability Period Duration (6 - 12 Months): _____

BENEFIT CONTRIBUTIONS

How Are Employee Contributions Made?:

☐ Payroll Deductions

☐ Other (Please Describe): _____

Employer Makes Contributions: ☐ Yes ☐ No

Employees Makes Contributions: ☐ Yes ☐ No

Include FMLA Provision in this document: ☐ Yes ☐ No

Include COBRA Provision: ☐ Yes ☐ No

Include Subrogation Provision: ☐ 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

Is your Group Health Plan "Creditable" with Medicare?: ☐ Yes ☐ No

Is your Group Prescription Plan "Creditable" with Medicare?: ☐ Yes ☐ No

HIPAA BENEFITS

Are any of the Benefits Subject to HIPAA?: ☐ Fully-Insured ☐ Self-Insured ☐ Both

If Fully Insured:

Should we include full HIPAA Provision in the Document?: ☐ Yes ☐ No

Should we remove all Self-Insurance language?: ☐ Yes ☐ No

If Self-Funded or HIPAA Provision is included, List Job Titles of Your HIPAA-Designated Employees: