**Wrap Plan Document Information Please complete or check all applicable blue items**

**A. Company Information:**

1. Name of adopting employer or Plan Sponsor: Plan Sponsor or lead Employer name

**2a.** Address line 1: Street address of PO Box

**2b.** Address line 2: Suite number

**3.** City: City **4.** State: State **5.** Zip: Zip

**6.** Phone: Area Code AC Number Fax: Area Code AC Number

**Additional Company Information:**

**8.** Plan Sponsor EIN: Tax ID number **9. F**iscal year end: Month Day, Year

**10a.** Entity type:

C Corporation S Corporation Non-profit Partnership Limited Liability Company

Limited Liability Partnership Sole Proprietorship Union Government agency Other

**10b.** If **10a** is "Union", enter name of the representative of the parties who established or maintain the Plan:

Union, local number or representatives

**10c.** If **10a** is "Other", enter Plan Sponsor entity type: Type of organization

**11.** State of organization of Plan Sponsor: State

**12a.** The Plan Sponsor is a member of an affiliated service group: Yes No

**12b.** If **12a** is "Yes", list name & EIN of all other members of the group:

EIN 1 Name 1

EIN 2 Name 2

EIN 3 Name 3

**13a.** Is the Plan Sponsor a member of a controlled group:  Yes  No

**13b.** If **13a** is "Yes", list name & EIN of all other members of the group:

EIN 1 Name 1

EIN 2 Name 2

EIN 3 Name 3

**Contact Information:**

**21.**  Salutation Name Title

Phone AC Phone number Fax AC Fax number

Email

**B. General Plan Information:**

**1.** Plan Number: \_ \_ \_ **2.** Plan name: ERISA plan name

**3a.** Original effective date of Plan: Month Day, Year

**3b.** Restatement of a previous plan? Yes  No **3c.** If "Yes", effective date: Month Day, Year

**4a.** Plan Year End: Month Day, Year

**4b.** The Plan has a short plan year: Yes No

**4c.** If “Yes", start date: Month Day, Year **4d.** end date: Month Day, Year

**C. Subsidiary Contracts:**

**1.** Include all ERISA benefits of Plan Sponsor and adopting Employers?Yes No, include only the following

a. Coverage 1

b. Coverage 2

c. Coverage 3

d. Coverage 4

e. Coverage 5

f. Coverage 6

g. Coverage 7

h. Coverage 8

i. Coverage 9

j. Coverage 10

**2.** Exclude specific coverages offered by the Plan Sponsor and adopting Employers?No Yes, exclude the following

a. Coverage 1

b. Coverage 2

c. Coverage 3

d. Coverage 4

**D. Plan Operations:**

**1.** Plan Administrator is Plan SponsorCommittee Other Name of Plan Administrator

**2.** Indemnification of Plan Administrator None Standard Custom Describe type of indemnification

**E. Full Time Employee Procedure (skip if not applicable):**

**1.** **New employees**

**a.** Initial Measurement Period (in months): 3 – 12,

**b.** Starting date of hire1st full payroll 1st of month Other describe start date

**c.** Initial Stability Period (in months): 6 – 12, not less than a.

**2.** **Existing employees**

a. Calendar month measurement for all employees specified employees Describe type(s) of employees

OR

lookback measurement for all employees specified employees Describe type(s) of employees

Standard Measurement Period in months ): 3 – 12

Standard Measurement Period starts SMP start date and ends SMP end date

Standard Stability Period starts SSP start date and ends SSP end date

**3.** Different Initial Measurement and Stability Periods for different employees?

If checked, describe different employee groups and applicable SMP and SSP’s Description

**F. Administrative Options:**

**1.** Method of employee identification: Social Security No.Employee ID No. .None

**2.** Plan Administrator address: Same as Plan Sponsor; or

Plan Administrator address line1

Plan Administrator address line2

Plan Administrator city Plan Administrator state Plan Administrator zip

Plan Administrator phone Plan Administrator fax Plan Administrator email

**3.** Agent for service: President of the Board or

Plan Agent name

Plan Agent address line1

Plan Agent address line2

Plan Agent city Plan Agent state Plan Agent zip

Plan Agent phone Plan Agent fax Plan Agent email

**4.** Plan funded by a trust? No; or

Trustee: Plan Sponsor; Plan Administrator; or

Plan Administrator address line1

Plan Administrator address line2

Plan Administrator city Plan Administrator state Plan Administrator zip

Plan Administrator phone Plan Administrator fax Plan Administrator email

**5.** Plan subject to a collective bargaining agreement? YesNo

**6.** Include COBRA language in SPD? No (skip to 4)Yes, and claims administrator is Plan Sponsor Other, and

Name of COBRA Administrator

COBRA Administrator Address

COBRA Administrator Phone

**7.** Number of days to notify COBRA administrator of qualifying events? (not less than 60) # days

**8.** Include claims language in SPD? YesNo

**9.** Include Women's Health and Cancer Rights Act language in SPD? YesNo

**10.** Include Newborns’ and Mothers’ Health Protection Act language in SPD? YesNo

**11.** Is the plan Grandfathered under ACA? YesNo