

WRAP Summary Plan Description Process

Welcome to the myHRcounsel wraparound summary plan description (“SPD”) creation process. We will provide you with an ERISA compliant SPD for your company.

In order to provide you with a complete SPD, we ask that you fill out the following questionnaire. It will provide us with guidance in order to ensure the SPD is fully legally compliant.

When the questionnaire is completed, save the document and return the electronic version along with an electronic copy of the prior SPD.

Upon receipt of the completed questionnaire and a copy of your SPD (if necessary), we will produce a draft copy for your review.

Once you have reviewed the draft, you can send us your comments or questions, if you have any. The draft and review process will continue until we have a final document. At that time, we will send you the final version of the SPD in electronic format.

## Plan Information

|  |  |
| --- | --- |
| Full legal name of the company: (e.g. Acme Products, Inc.) |  |
| Is this a multi-employer plan? | Choose ‘Yes’ or ‘No’. |
| Is the company the plan sponsor? | Choose ‘Yes’ or ‘No’.  If ‘No’, enter name of plan sponsor  Click here to enter text. |
| Plan sponsor address: | Click here to enter text. |
| Plan sponsor phone number: | Click here to enter text. |
| Plan sponsor’s EIN: | Click here to enter text. |
| Name of contact person at sponsor: | Click here to enter text. |
| Email address for contact person: | Click here to enter text. |
| Name of agent for service of legal processing: | Click here to enter text. |
| Address for service of process: | Click here to enter text. |
| Does the plan have a trust? | Choose ‘Yes’ or ‘No’. |
| If ‘yes’, enter the names, titles, and principal place of business of all trustees: | Click here to enter text. |
| Is the plan maintained pursuant to a collective bargaining agreement? | Choose ‘Yes’ or ‘No’. |
| Name of plan: (e.g. Acme Corp Health and Welfare Plan) | Click here to enter text. |
| Plan number (use corresponding number to form 5500 filing, if you file one): | Click here to enter text. |
| Plan year: (e.g. Jan 1 – Dec 31) | Click here to enter text. |
| Type of plan: (e.g. medical, dental, life insurance etc.) |  |
| Is the plan self-funded or fully insured? | Choose an item. |
| How will the plan be administered? (i.e. by the plan sponsor or third party) | Click here to enter text. |
| If a third-party will administrate, the name, address, and phone number of the company that is going to administer the plan: | Click here to enter text. |
| Is the company subject to FMLA? | Choose ‘Yes’ or ‘No’. |
| Is the company subject to COBRA? | Choose ‘Yes’ or ‘No’. |
|  |  |
| What are the eligibility requirements to enroll in plan? (feel free to attach separate sheet) | Click here to enter text. |
| What is the waiting period for enrollment? (feel free to attach separate sheet) | Click here to enter text. |