INFINISOURCE

ERISA Wrap Plan Information Worksheet

Please complete the below information and return via email to solutions@infinisource.com

Employer's federal tax identification number (EIN) ____________________ **Plan number** ____________________

Plan effective date (mm/dd/yyyy) ____________________

5500 Plan Year Start Date (mm/dd/yyyy) ____________________ **Affiliates** ____________________

Third Party Administrator (if applicable) ____________________ **COBRA Administrator** (if applicable) ____________________

List available benefits:

Benefit	Carrier name	Plan year (mm/dd)	Eligibility Terms	How is the plan funded? Fully or Self-insured	Insurer/Claims Administrator
Accidental Death and Dismemberment (AD&D)					
Cafeteria Plan					
Dependent Care FSA					
Dental					
Employee Assistance Program					
Group Term Life Insurance					
Health Reimbursement Arrangement					
Health FSA					
Long-term Disability Insurance					
Short-term Disability Insurance					
Medical Coverage					
Additional Medical Coverage (if applicable)					
Wellness Program					
Vision					
Other coverage					

Infinisource use only		MOA valid for 30 days from	
Internal agent #		Account #	
		Service effective date	

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