Premium Only Plan Questionnaire

Please complete this entire form, then securely upload via the MoneyWise Website. We will get back to you within one business day with next steps.

Employer Information

Employer Company Name	
Employer EIN	
Employer Organization Type	
Corporation, Limited Liability Company, Partnership, S Corporation, Sole Proprietorship, Non-Profit Organization, Estate, Professional Corporation, Governmental Entity or Church	
Employer Organization State	

Employer Primary Contact Information

Contact Name (First & Last)	
Address	
Address	
City	
State	
Zip	
Phone Number	
Email Address	

Affiliates (if applicable)

An affiliate generally means:

- Subsidiaries which are owned (at least 80% ownership) by the plan sponsor
- Other companies which are owned (at least 80% ownership) by a parent company which also owns 80% of the plan

Document Information

Would you like to add a custom appendix item to the table of contents? (if unsure choose no)	YES / NO

POP Questionnaire

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	mm/dd/yyyy	
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	mm/dd/yyyy	
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)	mm/dd/yyyy	
Amended and Restated Date (only if Restatement)	mm/dd/yyyy	
Short Plan Year	YES / NO	
Renewal Year Start (only if short Plan year)	mm/dd/yyyy	
State the date on which the Plan year that follows the short plan year will start.		
Renewal Year End (only if short Plan year)	mm/dd/yyyy	
State the date on which the Plan year that follows the short plan year will end.		

POP Questionnaire

Plan Benefits

Does your plan offer the following benefits? (YES / NO)

Group Medical Insurance		Long-Term Disability Insurance	
Group Dental Insurance		Short-Term Disability Insurance	
Group Vision Insurance		Accidental Death and Dismemberment Insurance	
HSA Contributions		Critical Illness Insurance	
Group Term Life		Hospital Indemnity Insurance	
Cancer Insurance		Cash In Lieu of Benefits	
Voluntary Benefits		Intensive Care Insurance	
Personal Sickness Indemnity		Specified Health Event	

Elections and Plan Options

Employee Elections	Election Required First Year Only / Election Required Each Plan Year / No Election Required, May Opt-Out	
Include Participant Election Forms	YES / NO	
Allow Change of Status if employee Full-Time status drops below 30 hours?	YES / NO	
Allow Change of Status if employee is eligible for a Special Enrollment or Annual Open Enrollment Period in a qualified Health Plan within a Marketplace?	YES / NO	
Allow a Change in Status in the middle of the plan year if an employee's dependent is eligible for a Special Enrollment to enroll in a Qualified Health Plan within a state or federal Exchange?	YES / NO	
Include FMLA Language?	YES / NO	