DENTAL WRAP CHECKLIST

General Information

Employer's Full Name: ____

Address: ____

____

Telephone: ____

Employer Identification Number: ____

Plan Sponsor *(if different from Employer)*: ____

Plan Administrator *(if different from Employer)*: ____

Plan Year: ____________________ through ______________________________

ERISA Plan Number: ____

Agent for Service of Process: ____

Address: ____

____

Telephone: ____

Trustees *(if any)*: ____

Address: ____

____

Telephone: ____

Original Effective Date: ____

Restated Date: ____
(Date when you plan to distribute this document – must be at least 20 days following submission)

Participating Employer(s): ____
____
____

(Employers whose employees are eligible to participate in this plan – must be affiliated companies – if you are unsure whether the entities meet ERISA's requirements for affiliation, please describe the relationship.)

Does HIPAA apply to the Employer(s)? Yes ______ No ______
(HIPAA applies to group health plans and group health insurance coverage for any plan year if, on the first day of the plan year, the plan has 2 or more participants who are current employees. It does not apply to any plan or coverage providing "excepted benefits," which include limited scope dental or vision benefits if offered separately from any other benefits.)

Does COBRA apply to the Employer(s)? Yes ______ No ______
(COBRA applies to all group health plans maintained by all public and private employers, other than churches; governmental entities of the U.S., the District of Columbia and U.S. territories and possessions; state and local government agencies that are not recipients of PHSA fund; and employers, including related employers, whose total number of employees (full-time and part-time), including leased employees, was less than 20 on at least 50% of the typical business days in the prior calendar year.)

Does FMLA apply to the Employer(s)? Yes ______ No ______
(FMLA applies to private sector employers of 50 or more employees and public agencies.)

Is this a Union Plan (maintained pursuant to a collective bargaining agreement): ________________
If so, what is the Name of the Union: ________________
If so, what is the Local Number: ________________
If so, what is the Local Location: ________________

Is this a Government Plan: ________________
If so, is HIPAA applicable: ________________
(A "Government Plan" is any plan established or maintained for its employees by the U.S. Government, the government of any state or political subdivision thereof, or by any agency or instrumentality of the foregoing. It also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act, and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act.)

Is this a Church Plan: ________________
If so, is HIPAA applicable: ________________
(A "Church Plan" is a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches which is exempt from tax under §501 of the Internal Revenue Code of 1954 ("IRC"). It does not include a plan where the employees or their beneficiaries are employed in connection with one or more unrelated trades or businesses (as described in IRC §513) or if less than substantially all of the individuals included in the plan are employees or beneficiaries. "Employee" means a duly ordained, commissioned or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation, or an employee of an organization which is exempt from tax under IRC §501 and which is controlled by or associated with a church or a convention or association of churches.)

Type of Benefit Plan: ***(Please list FULL name of plan (i.e., PPOBlue High Option II, Keystone HMO, etc.):***

Insurance Carrier: ________________

Are employees required to contribute for their coverage? Yes ____ No ____

Are employees required to contribute for dependent coverage? Yes ____ No ____

Definitions

"Employee" means a person who is a regular full-time *employee* of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-*employee* relationship. Such person must be scheduled to work at least [_____] hours per week and at least [_____] months per year in order to be considered "full-time."

Eligibility for Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself on the…

	1st day of the month following completion of a Service Waiting Period of [_____] days
	day of completion of a Service Waiting Period of [_____] days
	1st day following completion of a Service Waiting Period of [_____] days
	date of hire

Do you want the following provision: ________. If so, please complete the blanks.

If employment is terminated and the Employee returns to Active Employment within [____ days/_____months] from the date of termination, the Service Waiting Period will be waived and coverage will take effect on the first day the Employee returns to Active Employment.

Can an individual be covered simultaneously as an Employee and a Dependent? Yes ____ No ____

Does this Plan have an Open Enrollment Period? ________. If so, please complete the blanks.

Coverage for Participants enrolling during an Open Enrollment Period will become effective on [_______________] 1, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his Dependents will become effective on the day following completion of the Service Waiting Period.

"Open Enrollment Period" shall mean the month of [_______________] in each Plan Year.

Loss of Other Coverage
An *employee* who is already enrolled in a benefit package may enroll in another benefit package under the *Plan* if a *dependent* of that *employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage. The *employee* must make written application for special enrollment in the new benefit package within 30 days of the date the other health coverage was lost.
OPTIONAL – KEEP or REMOVE

New Dependent
If the conditions for special enrollment are satisfied, coverage for the *employee* and his or her *dependent(s)* will be effective at 12:01 A.M.:

For a marriage, on the…

	…date of the marriage.
	…first day of the calendar month following enrollment.
	Other:

Termination of Coverage

Termination Dates of Individual Coverage
Do benefits terminate on the:

	DATE of the month in which the event occurs
	LAST DAY of the month in which the event occurs

If an Employee is a member of the armed forces, is he or she still eligible for coverage under the plan?
Yes ____ No ____

If a Dependent is a member of the armed forces, is he or she still eligible for coverage under the plan?
Yes ____ No ____

Continuation of Coverage

Employer Continuation Coverage
Is coverage continued in the event of:

Yes	No	Item	For How Long
		Layoff	
		Total Disability – Temporary (3 months or less)	
		Total Disability – Permanent (more than 3 months)	
		Leave of Absence which does not meet the requirements of FMLA Leave	

Qualifying Events
Is legal separation a qualifying event? ____

Are Retirees eligible for coverage: Yes ____ No ____

How long does COBRA continuation coverage last?
When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*.
OPTIONAL – KEEP or REMOVE

HIPAA Privacy

Please list the TITLES ONLY of those persons who will have access to PHI. ***This list is REQUIRED, and must be in the Plan (reference to a website is not acceptable):***

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________