PLAN DOCUMENT SET-UP
PREMIUM ONLY PLAN

Employer/Plan Sponsor:

Legal name:_____ TIN:_____

Address:_____

City, State, Zip_____

Phone:_____ Fax #:_____

Contact Name:_____ Email:_____

Plan Information:

Effective date:_____ Plan year:_____

Premiums to be deducted pre-tax ☐ Medical ☐ Dental

☐ _____

A plan document draft will be sent for review and approval by the plan sponsor prior to sending a final copy. The plan sponsor is responsible for verifying that the information relative to your plan is correct. The plan sponsor agrees to pay the document fee of $150.00 upon receipt of the final copy.

_____ _____
Signature Date

Please return by one of the following methods:

Email to nancy.fee@3pa.com
Fax to 608-779-3009
Mail to 3PAdministrators, P.O. Box 247, Onalaska, WI 54650