ALLIED NATIONAL
A 90 Degree Benefits Company

FUNDING ADVANTAGE
A Level-Funding Solution for Small Groups

# Employer Application and Disclosure Statement

## Effective Date: _____

### A. Employer Information

Name of company assigned to Fed ID#/TIN provided

Type of company ☐ Sole Proprietor ☐ LLC ☐ Partnership ☐ S-Corporation ☐ C-Corporation ☐ Non-profit

☐ DBA Name _____ ☐ Fed ID# _____

| Street address (no PO Box) | | City | |
|---|---|---|---|
| County | State | ZIP code | |
| Mailing address (if different that street address) | City | State | ZIP code |
| Nature of business | SIC | Number of years in business | Number of years self-funded |

### B. Employee Participation

| | |
|---|---|
| Total number of full-time employees | Total number of part-time employees |
| Total number of seasonal, temporary and/or union employees | Total number of full-time employees applying for medical coverage |

Does Plan Sponsor's health plan exclude any class of employee from eligibility? ☐ Yes ☐ No
If "Yes", please describe the class(es) (any class exclusion must be non-discriminatory and approved in advance):

Plan Sponsor consents to periodic reviews of its employment records, for purposes of verifying the number and names of all employees eligible to participate in Plan Sponsor's health plan, and agrees to furnish, upon request, a current employee census and state unemployment tax report. ☐ Yes ☐ No If no, coverage will not be issued

Will any HRA, GAP or self-funded plan, be used to supplement this self-funded Plan? ☐ Yes ☐ No
(If Yes, please describe or provide a copy of the HRA/GAP benefit schedule):

For the Plan Benefits selected below, Plan Sponsor requests an effective date of _____. Plan Sponsor acknowledges that approval of the Stop-Loss Insurance is dependent upon all required paperwork being fully and properly completed, signed on or before the requested effective date, submitted to Allied National within five (5) business days thereafter, and then approved in writing.

Will this health plan be subject to a collective bargaining agreement? ☐ Yes ☐ No
Number of 1099 employees applying for medical coverage (Cannot be more than 50%)

### C. Contact Information – All contacts in this section must be an employee at the company and be authorized to receive Protected Health Information (PHI)

| Name of executive contact – will sign stop loss documents (owner/officer/partner) | | Title of executive contact | |
|---|---|---|---|
| Executive contact email address | Telephone number | | Fax number |
| Name of administrative contact if different from executive contact | | Title of administrative contact | |
| Administrative contact email address | Telephone number | | Fax number |

## D. Employers with Multiple Locations/Affiliated Businesses

Are there any employees to be covered that work at a subsidiary or associated company, or at location other than the one listed above? ..... ☐ Yes ☐ No

If yes, please list the location(s) and/or affiliate(s) below.

| Additional company location or affiliate name/address | Nature of business | Relationship to the company above | Tax ID | Number of employees |
|---|---|---|---|---|
| 1. | | | | Full-time:_____<br>Part-time:_____ |
| 2. | | | | Full-time:_____<br>Part-time:_____ |

Do you want the monthly billings broken out by the locations/entities above? ☐ Yes ☐ No

## E. Eligibility

Do you want to offer medical coverage to: Domestic Partners ☐ Yes ☐ No

If domestic partners are to be covered, plan will be set up with the standard domestic partner definition attached to this form unless a state defined definition is mandated. A Domestic Partner affidavit must be completed.

Elect a waiting period:

A. If hired on/before the effective date of the plan being established, an employee becomes eligible upon completion of: ☐ 0 months ☐ 1 month ☐ 2 months

B. If hired after said effective date, an employee becomes eligible on the first day of the month coinciding with or next following the completion of: ☐ 1 month ☐ 2 months

A fully completed enrollment form must be received by Allied National prior to the employee effective date.

Are any employees currently absent due to illness or injury, family medical leave or receiving disability benefits? ☐ Yes ☐ No
If yes, provide names and details:

Does the employer use a probationary period for new employees before the employee is considered as permanent full-time employee?
☐ Yes – How many months is the probationary period? _____
☐ No
Coverage for newly hired employees who work the required months during the probation period will be effective first of the month following the end of the probation period **and** the groups elected waiting period.

## F. Open Enrollment – The Plan provides for an annual open enrollment

| | |
|---|---|
| NOTE: Open enrollment must take place 30 days prior to renewal*<br><br>If the employer offers more than one plan option, employees may also elect to change from one plan option to another during the open enrollment | *Coverage selected during the annual open enrollment Period will be effective on the first day of the new policy year. Newly hired employee(s) must satisfy their waiting period. |

## G. Continuation/COBRA (Please note: COBRA continuation applies only to employers with 20 or more total employees)

| | |
|---|---|
| 1. Are any employees or dependents currently on COBRA or other continuation coverage?<br>If yes, list the individual(s) and the date(s) COBRA or continuation coverage began: | ☐ Yes ☐ No |
| 2. Are any employees or dependents currently in an election period for COBRA or other continuation coverage?<br>If yes, list the individual(s): | ☐ Yes ☐ No |

*Please note, an enrollment form and a copy of the COBRA election form/payment history must be submitted for each COBRA Participant that will be covered under your group plan.*

3. Who will perform COBRA administration?

| Name of vendor: | Address of vendor: | Phone number: | Vendor website |
|---|---|---|---|
| | | | |

4. Does the plan sponsor wish to have their COBRA employees billed on your group invoice or billed directly?

## H. Plan Sponsor Acknowledges

Plan Sponsor acknowledges and understands that the following minimum participation requirements will apply to the Plan Benefits selected below: For major medical and Cost Saver plans at least 75% of eligible employees after valid waivers; or 40% of all eligible employees must participate. Plan Failure to maintain this requirement for three (3) consecutive months will result in termination of

| |
|---|
| the Plan Benefits, **including the Stop-Loss Insurance**. If that occurs, Plan Sponsor will be liable for 100% of the cost of all claim payments under its Plan. |
| To defray the costs of employee coverage under Plan Sponsor's health plan, Plan Sponsor agrees to contribute _____% or $_____ to Employee Coverage (must be at least 25%); and _____% or $_____ to Dependent Coverage (optional – dependent contributions are not required.) |
| Plan Sponsor further acknowledges and understands that: Stop-Loss Insurance is an annual insurance contract and not guaranteed renewable; access to all available benefits under the Stop-Loss Insurance is subject to the Stop-Loss Insurance policy remaining in effect for the entire policy year and meeting the minimum specific and annual aggregate deductibles (as described in the Stop-Loss Insurance policy); and early termination of said Stop-Loss Insurance may result in reduction of benefits and/or increased claim exposure. |
| Plan Sponsor further acknowledges and understands that the only employees and dependents eligible for coverage under the Stop-Loss Insurance at the time of issue are those whose exact names and dates of birth were presented in the final submission and the final proposal signed by the Plan Sponsor. An incorrect name or date of birth will render that employee or dependent ineligible for Stop Loss Insurance coverage. I have reviewed and confirmed all names and dates of birth in the final proposal are correct. |

# CERTIFICATION & SIGNATURE

Plan Sponsor, by its authorized representative named below, acknowledges, agrees, accepts and/or consents to the following:

The Plan Benefits selected above represent a program of services designed for Plan Sponsor's health plan ("Plan") and includes the provision of a summary plan description for the Plan ("Plan SPD"), administrative services ("Delegated Services") and Stop-Loss insurance coverage ("Stop-Loss Insurance"). Plan Sponsor consulted with the agent of record and reviewed the Plan Benefits brochure and guide before making its selection. The specific benefits selected by Plan Sponsor for its health plan are stated in the signed proposal attached to the Stop-Loss Insurance application.

Plan Sponsor's health plan is a self-funded Employee Welfare Benefit Plan established for its employees. Certain rights granted by the "Employee Retirement Income Security Act of 1974" (ERISA), the "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA), the "Health Insurance Portability and Accountability Act of 1996" (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA), and other federal and state benefit laws apply to the participating employees. Plan Sponsor retains all plan sponsor, plan administrator and plan fiduciary responsibilities under said benefit laws. Plan Sponsor remains responsible for compliance with said benefit laws, including all mandatory notices to participants and all regulatory reports and filings. HIPAA guaranteed availability and renewability do not apply to the self-funded Plan Benefits or the Stop-Loss Insurance.

**No liability is created or assumed by the insurance company under the Stop-Loss Insurance until the Stop-Loss Insurance application has been approved in writing.** If for any reason the application is not approved, the sole obligation of the insurance company will be, and Plan Sponsor shall be entitled to only, a refund of any premiums paid. A claim incurred by a Plan Sponsor employee is eligible for benefits under the Stop-Loss Insurance only if that employee was covered under the Plan at the time the claim was incurred. Coverage under the Stop-Loss Insurance is based on the Plan SPD. Any change to the Plan SPD, or any benefit payment inconsistent with the Plan SPD, may not be covered under the Stop-Loss Insurance. Plan Sponsor shall reimburse the Stop-Loss Insurance for any ineligible benefits, including expenses incurred under the Plan's Outpatient Prescription Drug Card Benefit, and any advances issued pursuant to the accommodation provision in the Stop-Loss Insurance.

Plan Sponsor has engaged the agent of record shown below as its Plan consultant, to assist in establishing and/or maintaining the Plan and in securing the Plan Benefits (including the Plan SPD and Stop-Loss Insurance) and the Delegated Services. The agent of record will receive a portion of the fees charged for the Plan Benefits as compensation for those consulting services. The agent of record has no authority to bind the Stop-Loss Insurance or alter its terms.

Plan Sponsor has also engaged Allied National to act as the third-party administrator for the Plan, which includes the delegation to Allied National of certain non-fiduciary, ministerial administrative acts, duties or responsibilities on behalf of the Plan. The Delegated Services have been negotiated via a separate administrative services agreement, between the Plan Sponsor and Allied National, and are not part of the Stop-Loss Insurance. None of the premium charged for the Stop-Loss Insurance will pay for (or be allocated to) the Delegated Services, and none of the fees charged for the Delegated Services will pay for (or be allocated to) the Stop-Loss Insurance. If the Stop-Loss Insurance is not approved, Allied National will have no obligation to provide the Delegated Services to Plan Sponsor. Delegated Services include, but are not limited to:

- Tracking employee and dependent enrollment in the Plan;
- Billing, collecting, holding and disbursing Plan funds, from which to pay claims and Stop-Loss Insurance premiums;

- Providing utilization management services for inpatient admissions, maternities and certain outpatient services;
- Processing provider claims to determine and pay Plan benefits, as provided under the terms of the Plan;
- Billing, collecting and remitting agent of record consulting fees; and
- Arranging access to, and billing and remitting fees for, discounted fee arrangements (including managed care and pharmacy networks) and wellness programs (or similar employee support programs).

Employer and employee Plan contributions provided by Plan Sponsor (to pay benefits and loss adjustment expenses under the Plan) will be held in trust with similar funds provided by sponsoring employers of other plans, in an interest-bearing bank account administered by Allied National. All earned and accrued interest shall be retained by Allied National (as part of its reasonable compensation for the Delegated Services). If eligible benefit payments exceed Plan contributions, funds may be advanced to the employer by the Stop-Loss Insurance company (under the Stop-Loss Insurance accommodation provision). If eligible benefit payments exceed the agreed to specific or aggregate maximums, coverage becomes available under the Stop-Loss Insurance.

I have authority to represent and act on behalf of Plan Sponsor in submitting this Plan Sponsor Statement, the answers and information provided in this Plan Sponsor Statement are complete and true to the best of my knowledge and belief, and I understand that any material misrepresentation or omission in this Plan Sponsor Statement may nullify coverage under the Stop-Loss Insurance coverage.

List Owners: _____ Email Addresses: _____

Who is authorized to sign stop loss documents? _____

Signed at _____ Signature _____
City and State

Name (Print) _____

Date _____ Title _____
Must be signed by Owner, Partner or Officer

**Final monthly costs and eligibility are determined at the time of underwriting. DO NOT cancel current coverage until written notice of approval of Stop-Loss coverage has been received from Allied National.**

## I. Primary Broker Information and Statement

| Agency name | Broker name | Pay to Broker or Agency | Agency TIN |
|---|---|---|---|
| | | | |

| Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Email address | Telephone number |
|---|---|
| | |

| Does agency/agent require access to the online enrollment tool? | Does agency/agent require access to HR/Member website portal? |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |

X _____ Date _____

Will commission be split with another broker? ☐ Yes ☐ No
If yes, please complete the following information:

| J. General Agent/Agency Information | | | |
|---|---|---|---|
| Agency name | Broker name | Agency TIN | |
| Street address | City | State | ZIP code |
| Email address | | Telephone number | |
| Does Agency/Agent require access to the online enrollment tool?<br>☐ Yes ☐ No | | Does Agency/Agent access to HR/Member website portal?<br>☐ Yes ☐ No | |

| K. Request to Divide Compensation (Fee) Payment |
|---|
| Fee breakdown:<br>A. Primary broker: _____%  $ _____<br>B. General agent:_____%  $ _____ |

## Domestic Partner Definition

Domestic Partner means an individual who has satisfied all of the following:

1. Has an intimate relationship with an Employee of the same or opposite sex.
2. Shares the same principle residence as the Employee for a period of (12) consecutive months.
3. States his/her commitment to remaining with the Employee indefinitely.
4. Is not married to anyone else.
5. Is not related by blood closer than would prohibit marriage.
6. Is the Employee's sole Domestic Partner and neither has a different Domestic Partner.
7. Resides in a state where marriage between two persons of the same sex is not recognized as valid under the law, or if residing in a state where marriage is legal for same-sex couples, is married to the Employee, or if residing in a state that has some means of formal recognition of a Domestic Partner relationship (e.g., the Civil Union in the State of Vermont), has sought and received such recognition.
8. Is at least eighteen (18) years of age and mentally competent to enter into a contract under the law.
9. Is financially responsible for each other's welfare and shares financial obligations and provides proof of at least (3) of the following items:
    a. A joint lease/mortgage;
    b. Joint ownership of a motor vehicle (includes motor home or motorized boat), joint bank account, or joint credit account;
    c. Domestic Partner named as beneficiary of life insurance;
    d. Domestic Partner named as beneficiary of retired benefits;
    e. Domestic Partner named as primary beneficiary in the Employee's will;
    f. Domestic Partner assigned as power of attorney or legal designee;
    g. Both partners share household expenses (utility bills, receipts of major household items, care insurance); or
    h. Investments.

Employee will be liable for costs, fees, and expenses Incurred by the Plan Administrator if any Domestic Partner claimed is determined to be ineligible.

NOTE: The Employee and his/her Domestic Partner must sign an Affidavit of Domestic Partnership.

# Plan Sponsor Disclosure Statement – for groups enrolling 10 or more employees

Any person who knowingly and with intent to injure, defraud, or deceive submits this Disclosure Statement containing any false, incomplete, or misleading information may be guilty of a felony. Penalties may include imprisonment, fines, denial of benefits, and civil damages.

Name of Employer: _____

Key Contact: _____

Phone: _____ Email: _____

Employer Address: _____

Prior Carrier: _____ Type of Coverage: _____

_____

Before Allied National issues a stop-loss policy on behalf of _____

Allied National requires _____ to complete the following questions to the best of your knowledge for all eligible employees and dependents, including any COBRA beneficiary:

1. Have any employees or dependents, including those on COBRA, been hospitalized, had surgery, or had more than $50,000 in medical expenses, whether paid or not, in the last 12 months? ..... ☐ Yes ☐ No

2. Are any employees or dependents currently pregnant? ..... ☐ Yes ☐ No

3. Have any employees or dependents, including those on COBRA, been advised that hospitalization or surgery will be necessary in the next 12 months? ..... ☐ Yes ☐ No

4. Is there a covered person for whom a Prior Authorization, a Pre-Certification, or a Step Therapy Request for any Gene Therapy treatment, or is any covered persons expected to initiate or complete such treatment including but not limited to Kymriah, Yecarta, or Zolgensma? ..... ☐ Yes ☐ No

5. Within the past 2 years, has any employee or dependent, including those on COBRA, received or been scheduled to receive treatment for any of the following disorders or conditions?
   ☐ Cancer ☐ Injectable Medications
   ☐ End-Stage Renal Disease ☐ Transplant

If you answered "Yes" to any question above please provide the following details: (If needed, please include an additional page.)

| Question# | Employee/Dependent /COBRA | Age | Condition | Type of Treatment | Prescribed RX | Date last treated |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

As an owner, officer or partner of the above named Employer I attest that the above information is true, complete, and accurate to the best of my knowledge. I acknowledge that any false, or inaccurate statement or material misrepresentation in the Disclosure Statement may result in claim denial, a change in rate, or other changes to the terms and conditions for coverage hereunder. I further understand that if Allied National become aware of information, which if known prior to the effective date of this policy would have affected the rates, deductibles, terms or conditions for coverage hereunder, Allied National has the right to revise the rates, deductibles, terms, or conditions as of the effective date. I further agree that in order to complete tis Disclosure Statement I have consulted with the Carrier, Third Party Administrator, Broker, Human Resources Department, Pre-Certification Vendor, Large Case Management Vendor, Disease Management Vendor and Utilization Review Vendor to ensure the information provided in this Disclosure Statement is accurate and complete. I acknowledge and agree that previously or subsequently submitted documentation (e.g., a *claims exceeding $50,000 or claim filing) does not satisfy or alter the need to complete this Disclosure Statement or the consequences of failing to disclose a Covered Person that should have been listed on this form. I understand that Allied National has the right to revise rates retrospectively or prospectively for the stop-loss insurance contract if false, incomplete, or misleading information is provided on this form.

Owner, Officer or Partner Signature:_____

Date: _____