ASSURE GROUP APPLICATION

Employer Demographics Information						
		Effective Date:				
1	**Full Legal Name of Employer:** (remember that full legal names usually have an "INC", or "LLC", or "Corporation" at the end of the name)	Legal Name:				
2	**Does customer have a "Doing Business As" name (DBA name) that they want Network Health to use on member material? If so, what is your DBA name?**	DBA Name (if warranted):				
3	**Employer Tax ID # (as assigned by IRS):**	-				
4	**If subsidiaries/affiliates are included in the Plan that NH will be administering, do you want separate bills sent to each?**	☐ Yes ☐ No				
5	**List subsidiaries or affiliates to be covered by the Plan, if any:**	a. b. c.				
6	**Physical Address:**	Street				
		City		State		
		Zip		County		
7	**Mailing Address:** ☐ Check if same as Physical Address *List address if different from above*	Street or P.O. Box				
		City		State		
		Zip Code				
8	**Administrative Contact:**	Name				
		Title				
		Phone				
		Fax				
		Email				
9	**Nature of Business or Standard Industrial Classification (SIC)**					
10	**Number of Years in Business:**					
11	**Are any owners/officers/partners not legally required to be covered by workers' compensation, and need on-the-job medical coverage through this plan?** ☐ Yes (If yes, list names:) ☐ No					
12	Employer is a ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Labor Union ☐ Other:					
13	**Are you a member of a Chamber of Commerce?** ☐ Yes ☐ No If Yes, please list chamber name:					

Regulatory Information

1	**Please indicate all that apply:**	Is this group subject to ERISA? ☐ Yes ☐ No Is this group a governmental or church plan? ☐ Yes ☐ No Does your company receive financial assistance from any Federal department or agency? ☐ Yes ☐ No
2	**What is the three-digit plan number assigned to the plan for IRS purposes? (Default is 501)**	

Plan Information

Medical Plan(s) Selected (Maximum of four plans):

_____

_____

_____

_____

Prescription Drug Benefit

_____

Does Employer offer a Health Reimbursement Account (HRA) or Health Savings Account (HSA)? ☐ Yes ☐ No

If yes, name of vendor: _____

Please note that the Health Plan Document does NOT include information regarding any contribution the employer makes toward a HRA or HSA. The employer is responsible for providing their eligible employees with information regarding their HRA or HSA plan including any contribution the employer may make to it.

Eligibility Information

1	**Total number of current employees:**	
2	**Total number of eligible employees:**	
3	**Total number of eligible employees enrolling:**	
4	**Number of eligible employees waiving due to other coverage:**	
5	**Is Group subject to COBRA? (Averaged 20 or more Total Number of Employees during previous calendar year)** ☐ Yes ☐ No **Is your COBRA vendor Employee Benefits Corporation (EBC)?** ☐ Yes ☐ No **If no, do you want COBRA services through EBC (Included with the Assure product)?** ☐ Yes ☐ No	If you have a COBRA administrator other than EBC, please provide information in fields below. Name Street City / State Zip
	COBRA – Are any present or former employees or their dependents, including eligible owners, currently on or eligible to elect COBRA Continuation?	☐ Yes ☐ No **If Yes, complete the information requested below**

Name	COBRA Start Date	Qualifying Event (i.e. termination, job loss, divorce, etc.)

6	**How many hours does an employee need to regularly work to be eligible for the Plan?**	
7	**Check employee waiting period and effective date of coverage if it applies to all classes. If waiting period varies by class, please indicate below.** ***Termination for employees and dependents is the End of Month for all Assure groups.***	**First of Month** After (check below) ☐ Date of Hire ☐ 30-day waiting period ☐ 60-day waiting period ***OR*** **Immediately** After (check below) ☐ 30-day waiting period ☐ 60-day waiting period ☐ 90-day waiting period
8	**Do you want new employees currently in their waiting period to be eligible for benefits as of the date NHAS starts administering this Plan?**	☐ Yes ☐ No
9	**Do you want to separate employees due to billing or benefit provisions? If yes, please list:** (example: Hourly, 60-day waiting period, Salary, Immediately) Class Description _____ Waiting Period _____ _____ _____ _____ _____ _____ _____	

Payment Information–Payment of Initial Deposit	
☐ Direct Bill ($25 service fee will be added to monthly bill)	☐ ACH (Separate signed authorization form required)
Payment Information–Monthly Recurring Payment	
☐ Direct Bill ($25 service fee will be added to monthly bill)	☐ ACH (Separate signed authorization form required)
Paperless Billing Option: Please check: ☐ Yes ☐ No	Email address to send bill:_____

The Assure Group Application, Stop Loss Policy and Administrative Services Agreement comprise the terms and conditions of the contract.

Employer Fiduciary Responsibility

- Under the Employee Retirement Income Security Act of 1974 (ERISA), fiduciaries can be held personally liable for losses to a benefit plan incurred as a result of their alleged errors or omissions or breach of their fiduciary duties.
- ERISA is a federal law that sets minimum standards for employee benefit plans maintained by private-sector employers. ERISA regulates not just retirement plans, but virtually all employer plans that provide employee benefits, including health, life, profit sharing, disability, and employee leave. ERISA includes standards of conduct for those who manage an employee benefit plan and its assets, who are called "fiduciaries."
- A fiduciary is a person who holds a legal or ethical relationship of trust with one or more other parties (person or group of persons). A plan must have at least one fiduciary (a person or entity) named in the written plan, or through a process described in the plan, as having control over the plan's operation. Your fiduciary responsibility is outlined in the Administrative Services Agreement.
- Under ERISA Section 409, both employers (the plan sponsors) and outside providers hired in a fiduciary capacity (such as Network Health Administrative Services, as the plan administrator) are potentially exposed to significant liabilities. If a plan is not managed properly and/or benefits are lost because employees were not given adequate information or instruction, fiduciaries can be held "personally liable" to "make good" any losses that they're responsible for.
- Fiduciary liability insurance is the proper insurance that can protect against this liability. There are several ways to get fiduciary liability coverage. A company can purchase a policy directly. Similar coverage may also be established using directors and officers (D&O) liability, commercial general liability (CGL), or trust E&O/professional liability policies as long as those policies have attached an endorsement specifically tailored to cover fiduciary liabilities.

Network Health strongly recommends that employers obtaining coverage under the Assure product carry Fiduciary liability coverage as indicated in the Administrative Services Agreement.

☐ I acknowledge I have read this Employer Fiduciary Responsibility section.

Employer Group Certification

The undersigned, as authorized representative of the Employer Group ("Group") requesting Third Party Administrative services, certifies reading the entire completed application and that the information provided is accurate and complete. The Group agrees to provide documentation requested by NHAS, necessary to establish plan documents, stop loss coverage with NHIC, and other documents required for the Assure level-funded plan. Group attests that business records maintained by the Group can substantiate all information provided.

The Group also certifies that the insurance agent has explained the coverage, limitations and exclusions, other details of services applied for, and the rules and regulations of NHAS. This document will form part of the Administrative Services Agreement between the Group and NHAS. Group accepts and agrees to the provisions contained in this Assure Group Application.

Employer Representative (Must be authorized to purchase coverage for this firm)	Signature	
	Print Name	
	Date	
	Title	
Writing Agent	Signature	
	Print Name	
	Date	
	Title	
	Agency	