The Protect Plans

EMPLOYER APPLICATION
Administered by Meritain Health

Instructions for completing this agreement

- The employer or the employer representative must complete the entire Application form with signature.
- The agent must sign and date this agreement.
- A signed copy of the proposal/quote must accompany this submission.
- A check made payable to "Meritain Health for the first month's total payment must be sent to Meritain Health with a copy of this check attached to this application.

Requested Effective Date:

_____/_____/_____

1. Company Information

Full Legal Name of Company / Plan Sponsor

Street Address

City | State | Zip

Mailing Address

City | State | Zip

Company Contact

Contact Phone Number | Email Address | Contact Fax Number

Nature of Business | Date Company Established / / | SIC Code

Federal Tax Identification Number

Employer / Business Type (Check one): ☐ Single Employer ☐ Church or Government Agency ☐ Union ☐ Other

Employer contribution percentage is_____% ☐ Employee Only ☐ Employee and Dependents

NOTE: *The employer is required to contribute at least 25% of the monthly premium due for Employee only coverage.*

Are subsidiaries/affiliates to be included? ☐ Yes ☐ No If "Yes", list names and addresses: _____

If subsidiaries/affiliates are included, do you want separate bills sent to each of these subsidiaries I affiliates? ☐ Yes ☐ No

2. Benefit Information

List most recent/current insurance carrier(s) or TPA(s): _____

Current group health plan: ☐ Fully Insured ☐ Self-Funded

3. Workers' Compensation Information

Name of Workers' Compensation Carrier

Policy Number | Carrier's Phone Number

4. COBRA Information

Are you subject to COBRA? ☐ Yes ☐ No

NOTE: *You are subject to COBRA if you or your controlled group, as defined in 26 U.S.C. 1563, employed at least 20 full or part-time employees on at least 50% of the typical business days during the previous calendar year. You must include employees residing outside the U.S.*

Will Meritain Administer COBRA coverage? ☐ Yes ☐ No If no, please provide administrator information:

Name: _____

Address: _____

Phone: _____ Fax: _____

5. Medical Plan Selections

Employers may select any or all plans:

Protect Co-Pay Plans

- ☐ Protect 500 Co-Pay (001)
- ☐ Protect 1000 Co-Pay (002)
- ☐ Protect 2000 Co-Pay (003)
- ☐ Protect 3000 Co-Pay (008)
- ☐ Protect 4000 Co-Pay (004)

Protect HSA Plans

- ☐ Protect HSA 3000 (005)
- ☐ Protect HSA 4000 (006)
- ☐ Protect HSA 5000 (007)

6. Employee Information

Total number of full-time employees:	Total number of part-time employees:	Total number of eligible employees:

Total number of enrolling employees: _____

NOTE: *Minimum participation requirement: groups of 50 or fewer eligible employees: 75% of all eligible employees; groups of 51 or more eligible employees: 60% of all eligible employees. Eligible employees are those full-time employees without coverage elsewhere. If Employer contributes 100% of the employee premium, 100% of employees must enroll.*

Minimum hours (per week) required for eligibility: _____

NOTE: *Minimum of 30 hours per week, 48 weeks per year, which may be reduced to 20 hours per week by request.*

Is anyone in your group currently under COBRA, state continuation plan, or within their election period? ☐ Yes ☐ No

If yes, please list below: *NOTE: Any COBRA applications received after approval of this application may result in a rate adjustment or declination.*

Employee/Dependent	Termination Date of Original Coverage	Qualifying Event

6. Employee Information (continued)

Employee probationary period: ☐ 30 days ☐ 60 days

NOTE: *Employee effective date first month after probationary period.*

Employee Classes (define): ☐ Class I ☐ Class II ☐ Class III ☐ Class IV

Any excluded classes of employees? ☐ Yes ☐ No If "Yes", give descriptions and reasons _____

Does current health insurer /TPA extend coverage/benefits for disabilities after termination date? ☐ Yes ☐ No

If "Yes", please provide copy of policy, employee certificate and/or Summary Plan Description (SPD)

IMPORTANT NOTICE: *All eligibility information must be complete and accurate. Excess Loss Coverage may be rescinded, reformed or declined if employer provides false or misleading information.*

7. Special Requests

(Subject to written approval by Meritain Health and Excess Loss Coverage Carrier)

8. Applicant Agreement

The agent has explained the details of the coverage(s)/benefits and I, the undersigned, acknowledge reading the entire application, including the Claims Funding Agreement and Administrative Services Agreement. The answers I have provided are true and complete. I understand that the terms and conditions herein binds the applicant only when the applicant receives written approval.

Full Legal Business Name

Signature

Name

Dated on / /

9. Agent / Producer Information

To avoid delays in commission processing, please complete the following section in its entirety.

Writing Agent	**Second Writing Agent**
Writing Agent	Second Writing Agent
Agency	Agency
Agency License Number	Agency License Number
Commission Payable to: ☐ Broker ☐ Agency	Commission Payable to: ☐ Broker ☐ Agency
Phone	Phone
Email	Email
Fax	Fax
Commission Percentage	Commission Percentage

I have notified the employer not to terminate present benefits until notified in writing of acceptance of this application.

Broker Signature	Broker Signature
Date	Date

10. General Agent Information

General Agency Name	
General Agency Number	General Agency License Number
General Agency Contact	General Agency Phone
General Agency Email	General Agency Fax

11. Client Contact Information

Executive Contact:

Name	Title	
Phone	Fax	Email Address

Billing / Eligibility Contact: Receives billing statement. Updates ongoing eligibility.

Name	Title	
Phone	Fax	Email Address

Funding Contact:

Name	Title	
Phone	Fax	Email Address

11. Client Contact Information (continued)

Claim Contact: Knowledgeable of plan document and how benefits are to be paid.

Name		
Phone	Fax	Email Address

HR / Web Manager Contact: Primary HR contact and person responsible as Web Portal setup contact

Title		
Phone	Fax	Email Address

12. Employer Mandate

What is the total count of full-time employees including full-time equivalent employees? _____

NOTE: *If the answer to this Question is LESS THAN 100, and the client does NOT want to comply early, then nothing further is required to be answered.*

How are you determining your standard hours for full-time? ☐ 30 hours per week **or** ☐ 130 hours per month?

Are seasonal employees eligible for coverage if they meet the full-time employee status? ☐ Yes ☐ No

In determining eligibility for full-time and full-time equivalent employee status, are you using a measurement period (also referred to as a look-back period)? ☐ Yes ☐ No

If yes, the next 4 questions must be answered

For determining full-time employee status for ongoing employees, the length for all three periods must be defined.

Standard Measurement Period: _____ Standard Stability Period: _____ Administrative Period: _____

For determining full-time employee status for new variable hour, seasonal or part-time employees, the length of all three periods must be defined.

Initial Measurement Period: _____ Initial Stability Period: _____ Administrative Period: _____

What is the employee payroll period? ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Other: _____

Select which methodology is used in determining the hours of service credited.

☐ Measurement Period begins with the first day of the pay period that includes the first day of the Measurement Period and ends with the last day of the last pay period that ends on or before the last day of that Measurement Period.

OR

☐ Measurement Period begins with the first day of the pay period that follows the first day of the Measurement Period and ends with the last day of the last pay period that includes the last day of that Measurement Period.

13. Authorization for ACH Transfer

Please Print or Type

Meritain Health requires monthly premium to be paid by ACH Transfer after initial month

Group/Employer Name	Group #
Address	Telephone #

NOTE: *Please allow 2-3 weeks for direct withdrawal to take effect.*

Action (Check one): ☐ Enroll ☐ Change ☐ Cancel

1. I hereby authorize Meritain Health, 300 Corporate Parkway, Amherst, NY 14226, hereinafter called COMPANY, to initiate debit entries from my account indicated below and the depository name, hereinafter called DEPOSITORY, to debit the same account.
2. Withdrawal from the following account: ☐ Checking Account ☐ Savings Account
3. I understand that Meritain pulls funds from ACH accounts on the last Friday of the month prior to the month in which invoices are due.

Depository Bank Name	
Bank Routing Number	Account Number

4. I agree to allow the COMPANY to stop payment or posting of, reverse, or adjust any entry erroneously debited or credited to my account.
5. This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and manner as to afford the COMPANY a reasonable opportunity to act on it.

Print Name_____ Title (if applicable) _____

Signature _____ Date _____

MAIL this form with attached documents to: MERITAIN HEALTH, ATTN: ACCOUNTS RECEIVABLE, PO BOX 1652, AMHERST, NY 14226
EMAIL: ACCOUNTSRECEIVABLE@MERITAIN.COM

Below is the necessary information that may be required to authorize MERITAIN HEALTH to debit your source bank account:
ABA 04300026 **ACH company ID** 9000002010

Contact Accounts Receivable with any questions regarding ACH at (716) 319-5156

Please Attach Your Voided Check Here

(Scanned images of the check are also acceptable)