

NEW GROUP SUBMISSION CHECKLIST

Group Name	Contact
Contact Email	Contact Phone

Thank you for selecting The Protect Plans. Please email as attachments the following information to Enroll@ProtectPlans.Info. Forms may be found at www.ProtectPlans.Info/Enroll

1. For Employers and Employees

<input type="checkbox"/> Employer Application Please be thorough and do not leave questions blank or unanswered. If a question doesn't apply, please enter "N/A."
<input type="checkbox"/> Rate Sheet(s) Please sign and date rate sheets from your quote for the plans sold. Please do not send all proposed plans.
<input type="checkbox"/> Current Carrier Billing Please include the latest invoice available.
<input type="checkbox"/> Employee Enrollment Forms Please verify thorough completion of all forms and that your desired effective date is indicated
<input type="checkbox"/> Protect Plans Employer Certification for Self-Funding Please sign and date this document certifying the employer (Plan Sponsor) has reviewed the implications of self-funding.
<input type="checkbox"/> Personal Health Information Release Form To protect the privacy of employees and their dependents, the employer needs to list staff members permitted to have access to members' Personal Health Information. Broker should be included on this list along with those on their staff permitted to view PHI. Please submit at time of enrollment to facilitate follow-up during the underwriting process.
<input type="checkbox"/> TransAmerica Premier Life Insurance Company Disclosure Statement Required only if TransAmerica Premier Life is providing excess-loss coverage. or <input type="checkbox"/> Fidelity Security Life Disclosure Statement Required only if Fidelity Security Life is providing excess-loss coverage and claims information is not being provided.
<input type="checkbox"/> Wage Tax Report Most recent filing. Please reconcile this report by indicating on it which employees are enrolling, ineligible (e.g., part-time) or declining.
<input type="checkbox"/> IRS Form W-9 (Request for Taxpayer Identification Number and Certification)
<input type="checkbox"/> COBRA For Current Participants please provide: Member demographics, copy of COBRA Election Form, Qualifying Event Date, Qualifying Event Reason, Coverage being selected, Premiums paid through date. Will group have stand-alone COBRA administration? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please attach a list of coverages (dental, vision) and the COBRA rates to be used as of the new effective date. If "no" and Meritain Health will administer COBRA please complete Meritain Health COBRA Administration Form.

1. For Employers and Employees (continued)

<input type="checkbox"/> Claims History (If not provided previously) Please submit, for the past two years if available, medical and pharmacy claims experience and information concerning all claims over \$25,000. For groups providing two years of claims experience only, employees may skip medical questions (Section 7 of The Protect Plans Employee Application)
<input type="checkbox"/> Additional Information As requested by the underwriter, if any.

2. After Determination of Final Rates and Approval

<input type="checkbox"/> Mail Check for First Month Fees (Payable to Meritain Health) to: Lisa Harwell, Billing Department, Meritain Health, 300 Corporate Parkway, Amherst, NY 14226 NOTE: Client should not include payments for current COBRA participants. These should be submitted to your COBRA Administrator IMPORTANT NOTICE: Current coverage should not be cancelled until written approval is received from underwriters.

When submitting your first Protect Plan case or your first case with this Stop-Loss Carrier please submit the following, which may be found at www.ProtectPlans.Info/enroll/broker-agreements

3. For Brokers

Broker Name*	Broker Email*	Agency Name*
Optional: GA Name	GA Email	GA Contact

<input type="checkbox"/> Insurgency Benefits Producer Agreement and Exhibits Available from your general agent or through Sales@ProtectPlan.Info
<input type="checkbox"/> Meritain Health Broker Data Form
<input type="checkbox"/> Copy of Current E&O Policy
<input type="checkbox"/> Signed ACH Form Meritain Health will deposit compensation payments directly into the account indicated.
<input type="checkbox"/> W-9 Form
<input type="checkbox"/> Transamerica Employee Benefits Application for Appointment or <input type="checkbox"/> Fidelity Security Life Agency/Agent Data Sheet Determined by which carrier is providing excess loss coverage

4. Next Steps

Submitting your client's application through Enroll@ProtectPlans.Info delivers the material to Strategic Underwriting Solutions LLC, (SUS) the Protect Plan underwriters. SUS and Meritain Health, the Protect Plan administrator, may contact you for additional information. In addition, Meritain Health will provide your group with ID Cards and Plan Documents. Please remind your client not to cancel their current coverage until they receive written confirmation of approval in The Protect Plans from the underwriters.