The Protect Plans

MERITAIN HEALTH
An Aetna Company

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

- ☐ Employer Application
  Please be thorough and do not leave questions blank or unanswered. If a question doesn't apply, please enter "N/A."
- ☐ Rate Sheet(s)
  Please sign and date rate sheets from your quote for the plans sold. Please do not send all proposed plans.
- ☐ Current Carrier Billing
  Please include the latest invoice available.
- ☐ Employee Enrollment Forms
  Please verify thorough completion of all forms and that your desired effective date is indicated
- ☐ 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.
- ☐ 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.
- ☐ TransAmerica Premier Life Insurance Company Disclosure Statement
  Required only if TransAmerica Premier Life is providing excess-loss coverage.

  or

  Fidelity Security Life Disclosure Statement
  Required only if Fidelity Security Life is providing excess-loss coverage and claims information is not being provided.
- ☐ 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.
- ☐ IRS Form W-9 (Request for Taxpayer Identification Number and Certification)
- ☐ 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? ☐ Yes ☐ 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 Meritian Health will administer COBRA please complete Meritain Health COBRA Administration Form.

The Protect Plans

MERITAIN HEALTH
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1. For Employers and Employees (continued)

- ☐ 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)
- ☐ Additional Information
  As requested by the underwriter, if any.

2. After Determination of Final Rates and Approval

- ☐ 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

- ☐ Insurgency Benefits Producer Agreement and Exhibits
  Available from your general agent or through Sales@ProtectPlan.Info
- ☐ Meritain Health Broker Data Form
- ☐ Copy of Current E&O Policy
- ☐ Signed ACH Form
  Meritain Health will deposit compensation payments directly into the account indicated.
- ☐ W-9 Form
- ☐ Transamerica Employee Benefits Application for Appointment
  or
- ☐ 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.

[1] In California SUS does business as Strategic & Innovative Insurance Solutions, LLC

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

Fiscal Plan Year: The 12-month period upon which the Form 5500 is based on and filed. If you are a small group that does not file a Form 5500, the plan year must still be a 12-month period. Typically, this is the 12-month period beginning either: 1) the date open enrollment elections are effective; or 2) the date you normally make benefit changes.

- Is the group ERISA or NON-ERISA? ☐ ERISA ☐ NON-ERISA
- Profit/Non-Profit: ☐ For Profit ☐ Not for Profit

2. Benefit Information

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

Current group health plan: ☐ Fully Insured ☐ Self-Funded ☐ N/A - No Current Coverage

What was/is the original self-funded plan effective date? _____/_____/_____

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: _____

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

5. Medical Plan Selections

Employers may select any or all plans:

Co-Pay Plans

- ☐ 500 Co-Pay (001)
- ☐ 1000 Co-Pay (002)
- ☐ 2000 Co-Pay (003)
- ☐ 3000 Co-Pay (008)
- ☐ 4000 Co-Pay (004)
- ☐ 5000 Co-Pay (009)

HSA Plans

- ☐ HSA 3000 (005)
- ☐ HSA 4000 (006)
- ☐ 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.*

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 _____

Decline Continuation of Plan Coverage Due to Disability or Approved Leave of Absence: ☐ Yes

NOTE: *Checking Yes means you are declining an additional coverage period for medical and prescription drug coverage for Employees in the event of their disability or an approved leave for 60 days following the last day of their active employment. By selecting Yes, coverage will no longer be on the same terms and conditions as for active Employees. This coverage would have run concurrently with leaves qualifying under the Family and Medical Leave Act. Instead, Employees on leave will lose their coverage under this Plan upon the start of their disability or approved leave of absence, although they may be eligible for coverage under federal or state programs such as COBRA.*

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

Please provide the Contact Information for those involved in the administration of your plan.

NOTE: *Only one person may be the Primary contact for each section.*

Contact #1:

Name:	Title:	
Phone:	Fax:	Email:

Primary Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Additional Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

(continued)

Contact #2:

Name:	Title:
Phone:	Fax:	Email:

Primary Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Additional Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Contact #3:

Name:	Title:
Phone:	Fax:	Email:

Primary Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Additional Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

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 50 FTEs your are NOT required to complete the remainder of this section.*

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

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.

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 2 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: _____

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)

Protect Plans

Employer Certification and Acknowledgement Concerning Self-Funding

Congratulations. Like an increasing number of small and mid-size employers, you're embracing the advantages delivered by fixed-cost self-funded plans (sometimes called "level premium plans"). While there are a lot of similarities between fully-insured and self-funded employee benefit arrangements, there are significant differences and responsibilities, too. This Employer Certification and Acknowledgement form assures you understand those differences.

Self-Funding: Important Considerations

Self-funding is an alternative approach to financing an employee benefit plan. Large employers have long used self-funding to directly fund their expected claims while separately purchasing Excess Loss coverage (often referred to as "Stop-Loss coverage") to protect against catastrophic claims.

In choosing a self-funded plan, here are some important things to know:

- **Your Plan of Benefits:** The Protect Plan offers several PPO plans including some that are HSA-compatible. You, as the employer and Plan Sponsor, may choose to make one or more—or all—of these plans available to your employees.
- **Your Third Party Administrator**: The Protect Plans are administered by Meritain Health, an Aetna company. As your third party administrator (or "TPA") Meritain Health will, among other services:
    - Maintain proper funds on deposit for claims payment as received from you, the Plan Sponsor
    - Pay claims according to your plan document
    - Prepare claim reports or provide other data to you as Plan Sponsor and your Excess Loss insurer
    - Provide plan information and assist with filing government-required reports
    - Bill, collect and disperse fees, taxes and Excess Loss insurance premium for your Plan.
- **Your Plan Document**: Meritain Health will provide you with a plan document that contains all the provisions governing the Protect Plans. This includes important eligibility, benefits, limitations, exclusions, and termination provisions related to your coverage. Meritain Health will also provide you with employee benefit descriptions, employee and dependent identification cards and other documents related to the administration of your plans.
- **Your Excess Loss Carrier**: The Protect Plans cap your risk as Plan Sponsor by providing stop-loss coverage. These limits address the amount you, the Plan Sponsor, are required to pay for an individual's eligible medical claims (*Specific* Stop-Loss coverage) and the combined amount of all eligible medical claims the plan must pay during a given period (*Aggregate* Stop-Loss coverage). Together, they protect you from both high individual medical claims and a high volume of medical claims and prescription drug claims across your entire group.
    - **Specific Stop-Loss Coverage** protects against unexpected, high dollar claims on any one individual. Your Protect Plan quote identified the per-person "attachment point" or deductible. This is the amount you are responsible to cover of eligible medical claims for each member of your plan. A minimum amount may be required by law. Eligible claims above this attachment point are reimbursed by your excess loss coverage.
    - **Aggregate Stop-Loss Coverage** provides a cap on the amount of eligible medical and prescription expenses that you will pay, in total, for all members of your plan during a Contract Period. Aggregate Excess Loss coverage accumulates each month to the end of the Contract Period. If eligible claims paid out exceed the amount you've contributed to the claims fund up to that time don't worry. With the Protect Plans you're advanced these funds. Your subsequent claim fund contributions "pay back" this advance. **IMPORTANT NOTE**: Since Aggregate Excess Loss coverage is determined by your Contract Period, in the event you terminate coverage prior to the end of your Contract Period you will be responsible for all eligible medical claims that would have been covered by the Aggregate Excess Loss coverage.
- **Your Contract Period**: The Protect Plans all feature a 12/18 Contract period. This means that eligible medical claims incurred within the first 12 months of your coverage and paid within the 18 months from the start of the Contract Period are covered by the plan or Stop Loss coverage. The plan's total maximum costs for a 12/18 Contract period

Protect Plans

includes the costs for the six months of run-out claims—claims incurred in the first 12 months of coverage, but not submitted until the 13th month or later. **IMPORTANT NOTE**: Claims incurred during the first 12 months of coverage, but submitted after the 18th month of the Contract Period are *not* covered by your stop-loss coverage and are the responsibility of the member or you, the Plan Sponsor.

- **Claims Fund:** Your claims fund includes money set aside for eligible claims and expenses incurred by employees or dependents of the plan. These should not exceed the specific or aggregate stop loss limits, and can help reduce employer liability. There are situations, however, when additional claims funding may be required. These include:
    - Covering a fee for prescriptions not covered under the stop loss policy.
    - Having a shortage of funding stemming from the termination of an employee. Claim overpayments and/or adjustments may have to be paid depending on the timing of the termination.
    - Rising employee head count over the course of the stop loss policy. A change in the employee census could increase the attachment point calculation.
    - Covering a shortage of funds while more information regarding a claim is being collected.

Self-Funding Advantages and Disadvantages

Self-funding typically offers you, the Plan Sponsor, several advantages including:

- No premium tax is owed on the self-funded claim fund
- You may offer the same health plan in multiple states
- You have the opportunity to receive any surplus in your claims fund at the end of your 12/18 Contract Period. With the Protect Plans, you receive 100% of this surplus.

There are also disadvantages:

- You, the employer, assume all risk up to the Excess Loss coverage attachment points. Your monthly payments covers this exposure. And with the Protect Plans, if incurred eligible claims exceed the amount you've paid into the claims fund up to that time, and it's within the Contract Period as outlined in your policy, your Excess Loss carrier advances you the difference
- Employers' assets are exposed to liability created by legal action against the self-funded plan. This risk is reduced by working with reputable administrators and carriers like those available to you through the Protect Plans
- You, working through the Protect Plan underwriters and administrators, are providing services normally provided by an insurance carrier. This requires you to exercise discipline over exceptions concerning eligibility for benefits and other discretionary payments.
- There are some circumstances in which you may need to supplement your fixed payments to the claims fund.

Fixed-Cost Self-Funded programs with excess loss protection like the Protect Plans offers are an innovative way for many employers to maximize their employee benefit dollars. By signing, below, you certify that you have read and understand the above information and that the Protect Plans are part of a self-funded program and not a fully-insured program.

_____ _____

Your Company Name Date Certified

_____ _____

Your Name Your Title or Position

_____

Your Signature

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

MERITAIN HEALTH
An Aetna Company

Authorization for ACH Transfer

Please Print or Type

Group/Employer Name	Group #	Address	Telephone #

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 the last Friday of the month prior to the month in which invoices are due. I elect to have my funds pulled on the:

   ■ Last Friday of prior month in which funds are due for my invoice

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) Date

Signature

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)

MERITAIN HEALTH
An Aetna Company

SCRIP WORLD

Client Name _____

PHI AUTHORIZATION FORM

TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

The plan sponsor hereby authorizes the following employees and other authorized individuals, such as plan sponsor's broker, consultant or other authorized third party, to access PHI with respect to the plan. Please provide name, title or other identifiers below:

Employee, Broker, Consultant or other authorized third party	Add Remove Change	Title	Phone number	Email address	Access to web? (yes/no)
Mark Gastineau	☑ Add ☐ Remove ☐ Change	Protect Plans Program Manager	469-269-2226	mgastineau@insurgencybenefits.com	◉ Yes ○ No
Scott Geske	☑ Add ☐ Remove ☐ Change	Protect Plans Program Manager	469-269-2226	scott_geske@hotmail.com	◉ Yes ○ No
Jacqueline St.Hilaire	☑ Add ☐ Remove ☐ Change	Protect Plans Program Manager	972-523-6575	jsthilaire@insurgencybenefits.com	◉ Yes ○ No
	☐ Add ☐ Remove ☐ Change				◉ Yes ○ No
	☐ Add ☐ Remove ☐ Change				◉ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No

By signing below, I acknowledge that I have the authority to grant such access on behalf of the plan. I further acknowledge that the plan has an appropriate and fully executed business associate agreement in place with the authorized recipient, if not an employee. Information being shared with the authorized recipient is the minimum necessary in accordance with HIPAA.

Please select one:

☐ This authorization form includes all persons who may access PHI on behalf of the plan sponsor and supersedes any authorizations previously executed.

☐ This authorization form includes a change as to who may access PHI on behalf of the plan sponsor and does not replace all prior PHI authorization forms.

Signature of the plan sponsor: _____

Printed name and title: _____

Company name: _____ Date: _____