Administered by:
Mayo Clinic Health Solutions

EMPLOYER APPLICATION
For Self-Funded Products

EMPLOYER DATA

1. Full Legal Business Name of Plan Sponsor____________________

2. Street Address ____________________ City ____________ State ________ ZIP ________

3. Mailing Address (if different) ____________________ City ____________ State ________ZIP ________

   County ____________ Phone No. ____________ Fax No. ____________

4. Nature of Business ____________ SIC Code ________ Date Business Started ________ Federal Tax ID No. ________

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

6. Is this group a government agency or church group? ☐ Yes ☐ No

7. Is the PLAN subject to collective bargaining? ☐ Yes ☐ No If yes, union name: ____________ exp. date: ____________

8. Name of person for service of legal process ____________________

9. Employer contribution percentage is ________%. The employer is required to contribute a minimum of 50% of the employee only cost of the lowest cost plan offered or $150.00, whichever is greater.

10. List prior insurance carrier(s) or TPA(s) during previous two (2) years: ____________________

    ____

    MEDICAL Current group health plan (check one) ☐ fully insured ☐ self-funded

11. Name of workers' compensation carrier ____________________

12. Are you subject to COBRA? (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.). ☐ Yes ☐ No

13. 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 Name	Termination Date of Original Coverage	Qualifying Event

EMPLOYEE DATA

1. Total number of full-time active employees ____________

2. * Minimum hours (per week) required for eligibility ____________ * Minimum of 30 hours per week, 48 weeks per year, which may be reduced to 20 hours per week by request.

3. Total number of eligible employees ____________

4. * Total number of enrolling employees ____________ * Minimum participation requirement is 75% of all eligible employees (but not less than 50% of all full-time employees)

5. Employee Classes (Give descriptions, if applicable):

   Class I ____________ Class III ____________

   Class II ____________ Class IV ____________

6. Are you establishing a retiree class for medical? ☐ Yes ☐ No If yes, attained age ____________ Years of Service ____________

7. Any excluded classes of employees? ☐ Yes ☐ No If yes, give descriptions and reasons: ____________

8. Employee probationary period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (Minimum of 30 days required)

9. Employee effective date ☐ Immediate after probationary period ☐ First of month after probationary period

10. Employee termination date ☐ Immediate ☐ End of month

11. 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.

12. How many of your employees do not speak English? ____________________ Language(s) spoken ____

PLAN SELECTIONS

Medical: (Please fill in medical plans being offered to your employees.)

PLAN Option 1	PLAN Option 2	PLAN Option 3	PLAN Option 4
Plan Name (as seen on proposal) ___________________________	Plan Name (as seen on proposal) ___________________________	Plan Name (as seen on proposal) ___________________________	Plan Name (as seen on proposal) ___________________________
Deductible ______ Copay ______	Deductible ______ Copay ______	Deductible ______ Copay ______	Deductible ______ Copay ______
Employer Cost Share %________	Employer Cost Share %________	Employer Cost Share %________	Employer Cost Share %________
Network(s): _________________ ___________________________	Network(s): _________________ ___________________________	Network(s): _________________ ___________________________	Network(s): _________________ ___________________________

TERMINATION OF EMPLOYMENT WHEN EMPLOYEE SERVICES END

The Employer terminates employment after an employee has not worked for the Employer for ____________ work days (e.g. 3, 5, 10 working days). If labor laws such as FMLA or any other terms, conditions or contract of employment require that the Employer continues to employ an employee for a longer period of time, the Employer will give written notice to the TPA when the Employer terminates employment for that employee.

CLAIMS FUNDING AGREEMENT

Under the terms of my Plan service Agreement with the TPA, I have agreed to provide funds for benefit payments monthly or more frequently as required by the banking arrangement, and agree the TPA is under no obligation to pay plan benefits if I have not provided adequate funds. I understand that I am financially responsible for all eligible claims incurred while my Plan is in effect.

FUNDING OPTIONS

I have elected to provide funds for benefit payments under the following option:

☐ **Maximum Funding (Required for Groups with less than 100 Lives)**
The monthly Maximum medical claim liability will be remitted each month either with the monthly remittance for Fixed Costs to the TPA, or to a separate designated bank account, depending on the banking arrangement chosen to the right. This will cover the medical claims liability for the current contract period. I understand that self-funded dental/short term disability claims liability is not included in my Maximum medical claims liability. It is my responsibility to provide separate funding for my dental/short term disability claims liability on a monthly basis. If at any time there are not adequate funds available for my eligible medical claims, payment for claims will not be made.

BANKING ARRANGEMENTS

I have elected to establish banking arrangements for claims funding as follows:

☐ **Prefunding (Required for Groups with less than 100 Lives and Optional for Groups with 100 or more Lives)**
I will remit my monthly Maximum medical claims liability, as elected to the left, along with my monthly fixed costs by the first of each month to the TPA. I will also remit any necessary funds for my life/AD&D/dental/short term disability liability, if applicable, as billed by the TPA. My funding contribution will be held in a non-interest bearing account.

☐ **Cycle Funding (Billing) (Option available only for Groups with 100 or more Lives)**
I will designate an established bank account for claims funding. I will also establish a claims payment bank account at a designated bank. The TPA will process my claims on a weekly cycle. I will receive a Claims Funding Notification by fax each Monday. This notification will indicate the amount of funds that will be transferred by Automatic Clearing House (ACH) process transaction from my claims funding bank account upon the open of business on the following Wednesday. I agree to deposit into this claims funding account the claims liability as indicated by the TPA on the Claims Funding Notification on a weekly basis.

If your enrollment decreases, you will continue to be responsible for 85% (90% for 51+ Life Groups) of the monthly Maximum medical claim liability determined for the first month of the plan year. This is referred to as the minimum aggregate attachment point.
IMPORTANT: If you do not remit funds as required after notification by the TPA, administration of your Plan will be terminated. The Employee Retirement Income Security Act (ERISA) places a fiduciary responsibility on the employer, as Plan Sponsor, to ensure the Plan is adequately funded. The TPA may notify all Plan Participants, at your expense, if your claims account is determined to be in jeopardy.

BANK ACCOUNT FOR CLAIM PAYMENT

Please complete the information below to authorize checks or electronic funds transfer. This will allow the TPA to pay plan-covered services from the designated bank account. For more information on the process, see "Account Funding for Claim Payment Process."

Step 1 – Company Information

Name of Plan Sponsor/Company: ____

Starting Check Number ____________________ Tax Identification Number ____________________

Contact Name ____________________ Phone Number ____________________

FAX Number ____________________ E-mail Address ____________________

****NOTE: The Plan Sponsor will be asked to sign additional forms, including a Corporate Certificate of Authority Form and Signature Card.**

Step 2 – Bank Information

Name of Financial Institution: **Bank First National**

City: **Manitowoc** State: **WI** ZIP: **54221**

Phone Number : **920-684-6611** FAX Number: **920-652-3182** E-mail Address: ____________________

***NOTE: Bank First National is the preferred banking institution for this program. The Bank will assign applicable ABA and Bank Account Numbers as needed.**

Step 3 – Approval of Banking Options for TPA

Check Photocopy: Yes ☒ No ☐ Stop Payment: Yes ☒ No ☐

Item Inquiry: Yes ☒ No ☐ Image Positive Pay: Yes ☐ No ☒

AUTOMATIC CLEARING HOUSE (ACH)

ACH for Self-Funded Monthly Remittance

Name of Depositor ____
(print exact name as it appears on Financial Institution records)

Address ____ Phone No. ( ) ______________________

We hereby authorize the TPA to initiate debit entries to our checking account and the Financial Institution named below to debit the same to such account. The TPA will not be held responsible for a policy lapse or cancellation due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid.

Financial Institution Name ____________________________________ Branch ________________________

Financial Institution Phone No. ( ) ____

Street Address ____

City ______________________________________ State ________________ ZIP _______________

Transit/ABA No. _____________________________________ Account Number _______________________

This authority is to remain in full force and effective until either the TPA or the Financial Institution have received written notification from me of its termination in such time and in such manner as to afford the TPA and the Financial Institution a reasonable opportunity to act on it.

Name(s) ____

Date __________________________ Signature **X** ____

Email Address (Required) ______________________________________

Attach a voided check here

EFFECTIVE DATE / DEPOSIT
(Deposit must include the first month's fixed costs, plan set-up fees, and the first month's maximum claims cost.)

Requested effective date __________________________ Deposit with Application $ _________________________

IMPORTANT: Benefits are not effective until the undersigned receives written approval. No action is taken on the Application until all required information is submitted. The deposit amount will be returned to the Applicant if the Application is declined. **Make checks payable to "MMSI, Inc."**

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 Plan Services Agreement. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the applicant and the TPA only when the applicant receives written approval.

Dated at ____ (City & State) Dated on ____________________________________(Month, Day, Year)

Full Legal Business Name ____

Signature **X** ____ (Must be signed by a person authorized to purchase benefits for this firm)

Print Signature and Title ____

Mail Summary Plan Description (SPDs) to: ☐ **Employer's Business Address** ☐ **Agent's Address**

Identification (ID) Cards will be mailed to the Employer's Business Address.

Signed Copy of this Agreement and Excess Loss Policy acquired under separate application will be delivered electronically to the Employer's designated Internet address as follows: **Employer Internet Address:**_______________________
Check here if Employer prefers the documents to be mailed to the Employer's Business Address: ☐

AGENT INFORMATION

General Agent Name ____

Writing Agent Name ____ Writing Agent Name ____

Social Security / Identification Number ____________________________ Social Security / Identification Number ___________________________________

Street ____ Street ____

City _______________________ State ______________ Zip _________ City _________________________ State ________________ Zip ____________

Telephone Number ____ Telephone Number ____

Fax Number ____ Fax Number ____

Production Split _________________________ % Production Split ________________________ %

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

Agent Signature **X** ____ Agent Signature **X** ____

Date ____ Date ____

SPECIAL REQUESTS/COMMENTS/ADDITIONAL INSTRUCTIONS (Subject to written approval by the TPA)

INTERNAL USE ONLY

Effective date ___________________________________ Approved by ____ Date _______________________

Comments: ____