

ASSURE GROUP APPLICATION



Employer Demographics Information				
		Effective date:		
1	Full legal name of employer: (full legal names usually have Inc., LLC or Corporation at the end of the name)	Legal name:		
2	Do you have a “doing business as” (DBA) name you 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 Network Health will be administering, do you want separate bills sent to each?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Same as Physical Address List address if different from above	Street or PO Box		
		City	State	
		Zip		
8	Administrative contact:	Name		
		Title		
		Phone		
		Fax		
		Email		
9	Name of privacy officer, for the Privacy Policies and Procedures, if different than the administrative contact:	Name		
		Title		
		Phone		
		Fax		
		Email		

10	Nature of business or standard industrial classification (SIC)	
11	Number of years in business:	
12	Are any owners/officers/partners not legally required to be covered by workers' compensation, and need on-the-job medical coverage through this plan? <input type="checkbox"/> Yes (If yes, list names:) _____ <input type="checkbox"/> No	
13	Employer is a <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Labor Union <input type="checkbox"/> Government Entity <input type="checkbox"/> Church Plan (not a school or day care staff) <input type="checkbox"/> Other: _____	
14	Are you a limited liability company? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you a <input type="checkbox"/> C Corp or <input type="checkbox"/> S Corp?	
15	Are you a member of a chamber of commerce? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list chamber name: _____	
16	Did you have prior group medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the carrier: _____	

Regulatory Information

1	Please indicate all that apply:	<p>Is this group subject to the Employee Retirement Income Security Act of 1974 (ERISA)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Private employers, non-profit agencies and schools are all examples of ERISA groups. Generally, governmental entities and church plans are not subject to ERISA. We suggest you engage legal advice if unsure of being subject to ERISA.</i></p> <p>Does your company receive financial assistance from any federal department or agency? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If your company receives federal funding, you may be subject to Section 1557 requirements such as translation of documents. NHAS does not provide services to meet these requirements. We suggest you engage legal advice to ensure compliance.</i></p>
2	What is the three-digit plan number assigned to the plan for IRS purposes? (Default is 501) Please enter N/A for non-ERISA plans: _____	

Plan Information

	Medical plan(s) selected (maximum of four plans):
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Does Employer offer a health reimbursement account (HRA)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of vendor: _____																
Does Employer offer a health savings account (HSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of vendor: _____ Please note that the health plan document does not include information regarding any contribution the employer makes toward an 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	Are you a small or large group? Groups with 51 or more Full Time Equivalents (FTEs) are large groups. For more information visit www.irs.gov/affordable-care-act/individuals-and-families/aca-information-for-employers-counting-full-time-and-full-time-equivalent-employees		<input type="checkbox"/> Small Group <input type="checkbox"/> Large Group													
2	Total number of current employees: _____															
3	Total number of eligible employees: _____															
4	Total number of eligible employees enrolling: _____															
5	Number of eligible employees waiving due to other coverage: _____															
6	Is group subject to COBRA/Continuation? (Averaged 20 or more employees during the previous calendar year. Part-time employees are included but counted as a fraction of a full-time employee based on hours they work.)		<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to question #10.) <i>*Note: Refer to question #1 in the Regulatory Information section. State continuation is not available with level-funded plans.</i>													
7	Is your COBRA/Continuation administrator Employee Benefits Corporation (EBC)?		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, do you want COBRA services through EBC (included with the Assure product)? <input type="checkbox"/> Yes <input type="checkbox"/> No													
8	If you have a COBRA/Continuation administrator other than EBC, please provide information.		<table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Name</td> <td colspan="3"></td> </tr> <tr> <td>Street</td> <td colspan="3"></td> </tr> <tr> <td>City</td> <td style="width: 20%;"></td> <td style="width: 20%;">Zip</td> <td style="width: 40%;"></td> </tr> </table>		Name				Street				City		Zip	
Name																
Street																
City		Zip														
9	COBRA/Continuation – Are any present or former employees or their dependents, including eligible owners, currently on or eligible to elect COBRA coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the information requested below.													
Name: _____ COBRA/Continuation Start Date: _____ Qualifying event (i.e., termination, job loss, divorce, etc.) _____																
10	How many hours must an employee regularly work to be eligible for the plan? _____															

11	Please choose the ratio closest to your company's contribution values.		<input type="checkbox"/> 90% employer/10% employee <input type="checkbox"/> 80% employer/20% employee <input type="checkbox"/> 75% employer/25% employee <input type="checkbox"/> 70% employer/30% employee <input type="checkbox"/> 60% employer/40% employee <input type="checkbox"/> 50% employer/50% employee	
12	Has an eligible employee or dependent received or expected to receive more than 50 percent of the Specific Deductible in expenses in the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
13	Will any former employee or dependent be continuing coverage under the Plan in accordance with federal, state or local law on the Effective Date of this Policy, if issued?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
14	Are expected benefits available from the prior insurer for presently disabled eligible employees and/or dependents?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
15	Are any eligible employee or dependents presently disabled or confined in a hospital or similar facility?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
16	Check employee waiting period and effective date of coverage if it applies to all classes. If waiting period varies by class, please indicate below in question #14. Termination for employees and dependents is the End of Month for all Assure groups.	First of Month After (check below) <input type="checkbox"/> Date of hire <input type="checkbox"/> 30-day waiting period <input type="checkbox"/> 60-day waiting period OR Immediately after (check below) <input type="checkbox"/> 30-day waiting period <input type="checkbox"/> 60-day waiting period <input type="checkbox"/> 90-day waiting period		
17	Do you want new employees currently in their waiting period to be eligible for benefits as of the date Network Health Administrative Services starts administering this Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
18	How do you want to treat employees who are rehired? Large groups will be set-up as "Waive waiting period if rehired within 91 days" to be compliant with the ACA Employer Shared Responsibility requirements.	<input type="checkbox"/> Treat as a new employee <input type="checkbox"/> Waive waiting period if rehired within ____ days (Options are 30, 60, or 91 days.)		
19	Do you want to separate employees based on location or benefit provisions? If yes, please list. (example: hourly/salary, immediately/60 day waiting period)			
	Class	Name	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 Note: An invoice will be uploaded to the group portal on a monthly basis. An email notification will be sent out each month once the invoice is available to view.

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

NHAS will provide support for the Employer Group named in this document by delivering to their enrollees the required notices of nondiscrimination and availability, investigating, tracking and responding to discrimination complaints and/or providing free access to language assistance and auxiliary aids and services to the extent any of the above relate to the programs, services and activities administered by NHAS.

By checking the box below, the Employer Group named in this document agrees to provide documentation and assistance to comply with the applicable nondiscrimination rules to NHAS upon request.

☐ Yes, the Employer Group named in this document agrees.

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. These documents include, but are not limited to, the Administrative Services Agreement (ASA), Stop Loss Application, Business Associate Agreement (BAA), and Terms and Conditions sheet. If all necessary documents are not furnished to NHAS within 30 days of the date of this application, the offer for administrative services under the Assure plan will be withdrawn. 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	