ASSURANT Health®

TIME INSURANCE COMPANY
EMPLOYER STOP LOSS APPLICATION
for Assurant Self-Funded Program

Instructions for completing this agreement:

1) The employer or employer representative must complete the entire Application form with signature.
2) The agent must sign and date this agreement.
3) A signed copy of the proposal/quote must accompany this submission.
4) The first month's premium made payable to Allied Benefit Systems, Inc *must accompany this submission.*

Requested Effective Date: _____ / _____ / _____(Must be 1st or 15th, date subject to Underwriting approval)

SECTION A – EMPLOYER INFORMATION

1. Company Name: _____
   Full Legal Name of Company

   Doing business as (dba): _____

2. Employer address: _____
   Street

   _____
   City County State Zip

   Mailing address: _____
   (if different) Street City State Zip

3. Phone Number: (_____)_____ Fax Number (_____) _____

4. Contact Person and Title: _____

5. Email Address: _____
   By providing your email address you agree that you may receive your policy and/or certificate of issuance and other correspondence electronically.

6. Owner(s) Name(s): _____

7a. Is this a church organization? .....☐ Yes ☐ No

7b. Is this a religious affiliated organization? .....☐ Yes ☐ No

8. Nature of business/articles sold, manufactured, or service rendered: _____

9. Type of Ownership/Filing Status: ☐ Proprietorship ☐ Partnership ☐ C-Corporation ☐ S-Corporation ☐ Government Agency/Entity ☐ Other (specify)

10. Federal Tax Identification Number: _____

11. How long has this company been in business? _____

12. Employer contribution to premium *(must be a minimum of 50% of employee's premium)*: Medical _____%

13. Waiting/Affiliation Period *(the length of time future employees must be employed before becoming eligible for coverage)*:

    ☐ 0 days* ☐ 30 days* ☐ 60 days* ☐ 90 days
    *Note: the effective date will be on the first day of the billing cycle following the date the employee satisfied their waiting period and they enrolled for coverage within 31 days of becoming eligible for coverage.

14. Are you waiving the waiting/affiliation period for all employees enrolling for the group's original effective date? .....☐ Yes ☐ No

SECTION B – BENEFIT INFORMATION

1. Will this plan replace other group coverage? ..... ☐ Yes ☐ No

   If "Yes", please **provide 12 months of information below and provide a copy of the most recent billing for medical.**

Prior Medical Carrier(s)	Policy Number	Effective Date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)	Major Medical Plan?
				☐ Yes ☐ No
				☐ Yes ☐ No

2. Will you be or are you offering another group medical plan in addition to this group plan? ..... ☐ Yes ☐ No
3. Please select your Run-out Period. ☐ 6 months ☐ 12 months
   If not selected, a 6 month Run-out Period will apply.
4. Select either a ☐ Plan Year Deductible ☐ Calendar Year Deductible
5. Did you employ 20 or more full-time equivalent employees on at least 50% of typical business days during the previous calendar year? ..... ☐ Yes ☐ No
6. Do you want to offer COBRA if your current or future group size does not require this benefit? ..... ☐ Yes ☐ No
7. As part of this program, Allied Benefit Systems, Inc will administer your COBRA benefits.
   You may choose to use a different COBRA administrator. If you choose this option,
   list your COBRA administrator (if none listed, it will default to Allied): _____

SECTION C – AFFILIATED COMPANIES AND MULTIPLE LOCATIONS

1. Does your company have other business organizations under common ownership or more than one Federal Tax ID Number? ..... ☐ Yes ☐ No
2. Does your business have more then one physical location? ..... ☐ Yes ☐ No

If "Yes" to either question, complete the following. Indicate the number of full-time (FT) and part-time (PT) employees, whether enrolling or not (based on the **eligible employee** requirements in **Section D**).

Business Name *Address* *Owner(s)*

Nature of Business *Tax ID* *(FT)* *(PT)*

Business Name *Address* *Owner(s)*

Nature of Business *Tax ID* *(FT)* *(PT)*

Business Name *Address* *Owner(s)*

Nature of Business *Tax ID* *(FT)* *(PT)*

SECTION D – EMPLOYEE INFORMATION

All eligible full-time employees, including those in the new employee waiting/affiliation period, must submit an Enrollment Form or a Waiver of Coverage Form. If additional employees are hired between the date this application is completed and the date coverage is issued, completed Enrollment Forms or Waiver of Coverage Forms must be submitted within 5 days of date of hire.

1. Total number of employees (including owners, partners, etc.) working in your business?_____

2. How many are full-time employees? _____

3. How many are part-time employees?_____

4. Are any former employees or dependents on or eligible to elect continuation (COBRA or other)? ..... ☐ Yes ☐ No

Name	Start Date	End Date	Type of Continuation	Reason

5. Are any employees currently absent due to illness or injury, family medical leave, or receiving disability benefits? ..... ☐ Yes ☐ No

If "Yes", give names and details. _____

Eligible Employees

An eligible employee must meet the following requirements: a) performs services on a full-time basis; b) be considered an employee for federal employment tax purposes at any of the employer's business establishments (including all affiliated businesses listed in Section C above); and c) be 18 years old.

A partner, proprietor or corporate officer of the employer is eligible if he/she performs services for the employer on a full-time basis at any of the employer's business establishments.

The term "Employee" does not include: a) retirees or employees who are not expected to perform any duties, responsibilities or services for the employer; or b) "part-time" employees; or c) any "seasonal" or "temporary" employees who work only part of the calendar year on the basis of natural or suitable times or circumstances.

The Employer may select the number of hours (between 20 and 40) an employee must work each week in order to be considered full-time and eligible for coverage. If the employer does not select a full-time eligibility requirement, eligibility will be administered based on 30 hours per week.

Indicate the eligibility requirement between 20 and 40 hours per week _____

Employee Name	*E* = Enrolling *W* = Waiving	Employee Name	*E* = Enrolling *W* = Waiving
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

If additional space is needed, provide additional information on another sheet of paper.

SECTION E – AGREEMENT

I hereby apply for stop loss coverage in addition to services furnished for a self-funding small employer in association with the Assurant Self-Funded Program ("the Program"). The Program includes a stop loss insurance policy underwritten and issued by Time Insurance Company, services including underwriting and risk management enumerated under a separate Risk Management Services Agreement, and access to a licensed third party administrator for plan administration offered at preferred pricing. Through participation in the Program, I will receive access to services to assist me in creating and maintaining an employee welfare benefit plan under the Employee Retirement Income Security Act (ERISA), unless the plan is specifically exempt from the terms of ERISA.

For purposes of this agreement, I acknowledge and accept full and complete responsibility for the operation, administration, and maintenance of my group health plan in a prudent and diligent manner in the interest of the plan participants and beneficiaries, and I further acknowledge and understand that the group health plan I establish is not insurance. Unless the group health plan is specifically exempted, I also agree to comply with the fiduciary, reporting, and filing requirements of ERISA and to act in accordance with the duties and obligations set forth under ERISA, this agreement and any other applicable state or federal laws or regulations. I further acknowledge that Time Insurance Company is not the plan administrator or named fiduciary of my plan, as those terms are defined in ERISA. I agree to be solely responsible for compliance with all laws, including the payment of any required benefits that are not covered as illustrated in the Summary Plan Description or the stop loss policy. I further understand and agree that (1) services under the Program and the cost of providing those services may change; (2) those subject to evidence of eligibility must receive prior approval by Time Insurance Company at its home office before stop loss coverage becomes effective; (3) no services under the Program will become effective until the first full invoiced amount has been paid; (4) the cancelled check tendered as the first payment will be a receipt for deposit; (5) I or Time Insurance Company may discontinue or terminate the Program under certain circumstances identified in the stop loss policy, the Summary Plan Description and/or any additional Program agreements; (6) I will adhere to the contribution rules of Time Insurance Company regarding my contribution toward the employee cost of coverage and that stop loss coverage may be terminated if the contribution falls below the minimum contribution requirement; (7) all employees currently working for me are compensated in a manner that complies with all applicable federal and state requirements; (8) only eligible employees and their dependents are allowed to enroll; (9) all eligible employees must enroll now and in the future according to the participation rules of Time Insurance Company and that coverage may be terminated if the percentage falls below the participation requirements; (10) Time Insurance Company reserves the right to request a state wage and tax statement or other documentation at any time to verify current and future participation and eligibility; (11) the monthly maximum cost is subject to change until all of the following have occurred: a) the stop loss coverage has been approved by Time Insurance Company; (b) notice of effective date for the stop loss coverage has been furnished by Time Insurance Company; and (c) the first invoiced amount due for premium and services provided under the Program is paid; (12) the failure to pay the monthly invoiced amount in a timely manner will result in termination of participation in the Program, including stop loss insurance and other Program services; (13) I must give notice to the third party administrator within 30 days of any participating employee who ceases working the established eligible hours as defined on this application, including, but not limited to those on paid or unpaid leave, disability, salary continuation or worker's compensation.

Any person who, with intent to defraud or knowing that they are facilitating against Time Insurance Company in submitting an application form or claim containing a false or deceptive statement, may be guilty of insurance fraud as specified by any applicable State law.

I hereby agree to be bound by all the terms and conditions of the Program, including the terms and conditions outlined in the stop loss policy. I understand that the benefits I have selected for my self-funded group health plan are reflected on the attached signed proposal which is part of this request for participation in the Program.

The Employer represents the following:

I have read the Program brochure, and any applicable supplements, and understand the Program and stop loss coverage they describe.

As the participating employer or person acting with the authority of the participating employer, I certify that this information is complete and true to the best of my knowledge and belief. I fully understand that participation in the Program, including coverage under the stop loss policy, is not effective without the approval of Time Insurance Company. It is further understood that no agent has the authority to alter or amend any Program agreements, the self-funded health benefit plan I have established, or the stop loss policy, to adjust any claim for benefits, or to bind Time Insurance Company by making any promise or representation.

I understand that any material misstatement and/or omissions may void or terminate participation in the Program, including stop loss coverage.

By signing below, I certify that I have read the entire Employer Application, agree to all terms and conditions contained therein and that all information provided is true and accurate.

Signature of Employer_____ Title _____

Print Name of Employer _____ Date _____

SECTION F – AGENT CHECKLIST

1. **Make sure all sections are fully completed**
2. **Include the following documents with your application:**
   - Signed and dated proposal indicating stop loss and plan design options
   - Administrative Services agreement
   - Risk Management Services agreement
   - HSA Enrollment Form, if applicable
   - HRA Enrollment Form, if applicable
   - All eligible employee enrollment/waiver forms
   - Your last billing notice from your current carrier, if replacing coverage
   - Any state-specific forms
   - Signed network agreement, if applicable
   - New York Pool or TPA Change Form
   - State Quarterly Wage and Tax report
   - Business Associate Agreement
3. **Send a check or completed ACH form for the first month's bill to:**
   Allied Benefit Systems, Inc.
   200 West Adams Suite 500
   Chicago, IL 60606
   Attention: Accounting Department
4. **Send your completed application and other required documents to your sales office**

Time Insurance Company may request that the employer provide additional documentation (e.g. Payroll Records, Business License, etc.) during the underwriting process or at any time while coverage is provided by Time Insurance Company to support that eligibility and participation requirements are met.

SECTION G – AGENT'S STATEMENT

I certify that all of the information contained in the Employer Application and any additional documents submitted are correct to the best of my knowledge. I have complied with all of the underwriting rules and have fully explained the Program and stop loss coverage to the employer.

Agent's Signature: _____ Date: _____

Print Agent's Name: _____ Agent #: _____

Agent's Address: _____ Agent's Phone #: (_____) _____

Agent's City, State, Zip: _____ Agent's Fax #: (_____) _____

Agent's Email Address: _____

SECTION H – DISTRIBUTION PARTNER'S INFORMATION (Complete all applicable fields)

Office Name: _____ Office #: _____

Representative Name:_____ Representative #: _____

Representative Phone #: (_____)_____ Representative Fax #: (_____)_____

Email Address: _____

ASSURANT Health®

Claims Refund Agreement
Addendum to the Assurant Employer Application

At the end of your Plan's run-out period, you, the employer, may have an Excess Claim Fund Amount. This will occur if what you paid to Allied Benefit Systems, Inc (Allied), as part of your monthly bill to cover claims incurred during that Plan year exceeds the amount of claims processed by Allied for that same Plan year. Therefore, if the amount you paid to fund Plan year claims is more than the Plan year claims processed, you will have an Excess Claim Fund Amount.

At the end of your run-out period, Allied will return the Excess Claim Fund Amount to you in the form of a check. As a result, it is important that you understand, agree to, and acknowledge the following so that your use of the Excess Claim Fund Amount is done in accordance with the Employee Retirement Income Security act of 1974 (ERISA):

- You can attribute the Excess Claim Fund Amounts solely to contributions you, the employer, made to the plan and these funds are not "plan assets" as defined by ERISA and the applicable guidance there under.
- If you determine that these Excess Claim Fund Amounts are attributable to plan assets, whether in whole or in part, you agree to handle the Excess Claim Fund Amounts in accordance with the applicable rules and regulations of ERISA. That is, any and all amounts you determine to be plan assets must be used exclusively for the benefit of the Plan participants.
- The return of the Excess Claim Fund Amounts to you by Allied, at your request, does not constitute a breach of the Administrative Services Agreement by Allied.
- The return of the Excess Claim Fund Amount does not waive any obligation you or the Plan have under the Administrative Services Agreement to provide the necessary funds to pay any Plan claims incurred during the Plan year which would have been covered by this Excess Claim Fund Amount had it not already been returned to you. Should such a Plan year claim become payable after this Excess Claim Fund Amount was returned to you, it will be your responsibility to fund these claims upon request from Allied.