HEALTH OHIO NETWORK
A KALEIDOSCOPE OF CARE℠

Companion Life

Preferred United Plans®
"Alternative Funding"

SECUREONE℠
Benefit Administrators, Inc.

EMPLOYER APPLICATION

COMPLETE ALL INFORMATION TO AVOID PROCESSING DELAYS. TYPE OR PRINT CLEARLY IN INK.

SECTION I - EMPLOYER INFORMATION

Full Legal Name of Employer _____

Employer Tax Identification Number (TIN) ( )- _____

Street Address _____City _____State _____Zip _____

Phone Number (_____) _____ Fax Number (_____) _____

President: _____ E-Mail Address: _____

H.R. Dept. Contact: _____ E-Mail Address:_____

HIPAA/Privacy Officer:_____ E-Mail Address: _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

Monthly billings will be sent electronically. An e-mail notification will be sent. We need two different e-mails to use for these notifications:
Primary E-Mail: _____ Back-up E-Mail: _____

Do you want to allow your agent to have online access to your company's information? ☐ Yes ☐ No

Business Legal Status: ☐ C-Corp ☐ S-Corp ☐ Partnership ☐ LLC ☐ Other _____
Nature of Business _____ SIC Code: _____
Year Business Established _____

Any Subsidiaries and/or Affiliates to be Included ☐ Yes ☐ No If Yes, separate listing of subsidiaries and contact information: _____
_____

Are you replacing other Group Health Insurance?☐Yes ☐No If Yes, please submit a copy of the current carrier's policy or certificate and last billing statement.
Effective date of Current Group Health Plan _____ Termination Date of Group Current Health Plan _____
Name of current insurance carrier _____ Policy or Group Number _____

Do you currently have or want a HRA with "Alternative Funding"? ☐ Yes ☐ No
If yes, SecureOne Benefit Administrators, Inc. requires a complete description of Employer's HRA. SecureOne Benefit Administrators, Inc. is required to administer all HRAs under the PUP "Alternative Funding".
Fees: ☐ Simple 1 Tier Plan - $6.00 PEPM ☐ More than 1 Tier; Price Negotiated

Participation Requirements

- Employers with 5 employees or less require 100% participation regardless of the reason for waiving (i.e. spousal, Medicare, parental, etc.)
- Employers with 6-10 employees require a minimum of 5 enrolling regardless of the reason for waiving (i.e. spousal, Medicare, parental, etc.)
- Employers with 11-99 employees require:
  - 75% of all full-time eligible employees*
  - Minimum of 50% of all full-time employees regardless of the reason for waiving (i.e. spousal, Medicare, parental, etc.)

*Those waiving due to spousal coverage, Medicare or parental coverage are not counted as eligible for this participation requirement.

A group may be non-renewed if the participation requirements are not met. SecureOne may, upon its discretion, request a current payroll file or wage and tax statement for participation verification requirements.
Life Insurance is mandatory for all employees, even those who are waiving coverage, with a minimum amount of $15,000.

Effective Date: _____**, 20**_____ Employer Premium Contribution: Employee ____% Dependents ____%

Waiting period for new employees enrolling for coverage (choose only one):
☐ First of the month, following date of hire ☐ First of the month, following 30 days
☐ First of the month, following 60 days ☐ 90 days

SECTION II - EMPLOYER ENROLLMENT DATA

1. Do you have a class of employees that is ineligible (i.e., union, management, etc.)? ☐ Yes ☐ No

   If yes, list classes of employees to be excluded: _____

2. Identify the number of employees in the following categories: (If not applicable, indicate N/A)

Employee Status		Currently Covered by:		Number Enrolling In:	
Full Time	_____	COBRA Continuation*	_____	Life/AD&D	_____
Part Time	_____	State Continuation	_____	Health	_____
Temp or Contract	_____	Medicare	_____		
In Waiting Period	_____				
In Ineligible Class (refer to question #1)	_____				

Is your group eligible for COBRA Continuation (averaging 20 or more employees in the previous calendar year)? ☐ Yes ☐ No

*SecureOne Benefit Administrators, Inc. will be administering all COBRA.

3. If any employees are indicated above as covered under a COBRA or a State Continuation Plan in question #2, please list employees and dependents below.
   (Attach additional list, if needed):
   NOTE: If COBRA eligible or currently on COBRA, an Employee Application must be completed.

Name	EE/DEP	Date Continuation Began or Date Eligible for Continuation	Type of Continuation*

*Please indicate current enrollment type: Single, Employee/Spouse, Employee/Child(ren), or Family.

4. Are any employees currently absent or are any dependents confined to home or incapacitated due to illness, injury, or total disability?
   ☐ Yes ☐ No If Yes, please list (Attach additional list, if needed):

Name	EE/DEP	Date Illness, Injury or Total Disability Began	Type of Illness, Injury or Total Disability

5. **ANNUAL OPEN ENROLLMENT**

   The Annual Open Enrollment under Preferred United Plans® "Alternative Funding" will begin thirty (30) days before the effective date. The enrollment period will not exceed thirty one (31) days.

   The Plan Sponsor (Employer) is responsible to advise all of its employees (and dependents) of the annual open enrollment period.

   NO LATE ENTRANTS WILL BE ACCEPTED!

SECTION III - "Alternative Funding Election of Coverage

Please indicate the medical benefits group health plan and deductible you would like to provide for your employees:

Medical Plan – PPO

☐ **100/70** Deductible: ☐ $1,000 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000

☐ **90/60** Deductible: ☐$500 ☐$1,000 ☐$1,500 ☐$2,000 ☐$2,500 ☐$3,000 ☐$3,500 ☐$4,000 ☐$4,500 ☐$5,000 ☐$5,500 ☐$6,000

☐ **80/50** Deductible: ☐$500 ☐$1,000 ☐$1,500 ☐$2,000 ☐$2,500 ☐$3,000 ☐$3,500 ☐$4,000 ☐$4,500 ☐$5,000 ☐$5,500 ☐$6,000

☐ **70/50** Deductible: ☐$500 ☐$1,000 ☐$1,500 ☐$2,000 ☐$2,500 ☐$3,000 ☐$3,500 ☐$4,000 ☐$4,500 ☐$5,000 ☐$5,500 ☐$6,000

Coinsurance: ☐ % of 15,000 ☐ % of $20,000 **Emergency Room Co-Pay Options:** ☐ $150 or ☐ $250

Office Co-Pay for All Plans: $30.00

HSA - ☐ **100/70** Deductible: ☐ $1,350 ☐ $1,500 ☐ $2,000 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $6,000

☐ **80/60** Deductible: ☐ $1,350 ☐ $1,500 ☐ $2,000 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $6,000

Deductible and Coinsurance SEPARATE in and out of Network

The PPO will be Cofinity with MultiPlan being used for Non-Michigan claims.

Prescription Drug (Rx) Program: 25% co-pay for all Level IV drugs, limited to $5,000 per member co-pay per calendar year.

☐ **$5 Generic/$25 Preferred Brand/$50 Non-Preferred Brand*** ☐ **$15 Generic/$40 Preferred Brand/$80 Non-Preferred Brand***

☐ **$20 Generic/$60 Preferred Brand/$100 Non-Preferred Brand***

*Mail order co-pay is 2.5x retail co-pay, 90 day supply

LIFE INSURANCE, DEPENDENT LIFE AND AD&D BENEFITS

Life Insurance is mandatory for all employees, even those who are waiving coverage, with a minimum amount of $15,000.

Please indicate the Life Insurance benefit amount. ☐ Minimum $15,000 ☐ Other _____

Do you wish to provide Dependent Life Insurance? ($7,500 Spouse, $2,000 Child 6 months and older, $100 Child 14 days-6 mo.) ☐ Yes ☐ No

Note: Guaranteed issue amounts vary by size of group. Standard ADEA age reduction starting at age 65 applies.

COBRA

SecureOne Benefit Administrators, Inc. will be administering the COBRA at no cost.

Upon election of COBRA, SecureOne Benefit Administrators, Inc. will keep the additional 2% surcharge applied to the participant's premium.

"ALTERNATIVE FUNDING" REQUIREMENTS FROM PLAN SPONSORS (EMPLOYER)

The following materials must be completed and submitted to avoid delays in final underwriting:

☐ **Employee Health Risk Assessment Applications***

☐ **Copy of Current Policy**

☐ **Copy of Current Billing Statement**

☐ **Copy of Renewal Notification with Rates from Current Carrier**

☐ **Complete written description of HRA plan (if applicable)**

☐ **Copy of Employer's Most Recent Wage & Tax Report**

☐ **Binder Check for First Month's Fee $ _____**
(Payable to Preferred United Plans®)

ALL INFORMATION MUST BE FURNISHED FOR A COMPLETE EVALUATION

***Employees in their waiting periods must be included and/or complete the appropriate Employee Health Risk Assessment Application.**

FUND REQUIREMENTS (VERY IMPORTANT)

Preferred United Plans® "Alternative Funding" is a self-insured program being administered by SecureOne Benefit Administrators, Inc. with stop-loss coverage by Companion Life Insurance Company. We require prompt and full payment based upon our billing.

SecureOne Benefit Administrators, Inc. will bill the Employer (Plan Sponsor) electronically on the 15th of each month for the next month's fee requirements. The money is due on the first day of the month. SecureOne Benefit Administrators, Inc. will require payment by ACH or wire transfer. Should requested fee not be in by the first day of the month, all claims, eligibility and Rx will be placed on hold or terminated. Should providers and employees call for verification, eligibility or status, they will be informed of lack of payment.

If by the 10th of the month, monies are not received, the plan will be terminated. At any time during a month, should the employer's (plan sponsor) claims exceed the monthly "claim factors", the stop-loss carrier (Companion Life Insurance Company Life) is 100% responsible for the funding of those claims, unless the employer terminates prior to the end of the contract period or is late in payment.

Should the Employer (Contract Holder) terminate the contract prior to the contract end, the Employer (contract holder) remain liable for the minimum aggregate deductible and minimum aggregate premium as delivered in the contract schedule. The Employer (Contract Holder) shall pay Companion Life Insurance Company (the Company) the lessor of a) the minimum annual aggregate deductible and premium set forth in the contracts schedule less the cumulative total premium and aggregate claims paid to date by the Employer (Contract Holder) or b) the cumulative total outstanding accommodations paid by Companion Life Insurance Company (the Company).

Should the Employer (Plan Sponsor) terminate the Service Agreement contract with SecureOne Benefit Administrators, Inc. prior to the contract end, the Employer (Plan Sponsor) will remain liable for all Administrative Fees up to the term of the contract. Should the Employer (Plan Sponsor) want to be reinstated, a $1,000 reinstatement fee is required and the group must go through the new business process again.

EMPLOYER (PLAN SPONSOR) UNDERSTANDING

The Employer (Plan Sponsor) has read the complete proposal of the Preferred United Plans® "Alternative Funding"; with a complete understanding this is based upon the program's Schedule of Benefits and Master Plan Document. The Employer has no authority to change, manipulate or order payment of claims not covered by the Plan Document and Aggregate Stop-Loss Contract. The Employer (Plan Sponsor) has read or has been educated by the agent of the programs limitations and exclusions. All taxes or fees imposed by the State or PPACA are the 100% responsibility of the Employer (Plan Sponsor), to be paid upon request by SecureOne Benefit Administrators, Inc. SecureOne Benefit Administrators, Inc. will collect and submit payment to Michigan Department of Treasury for the 1.0% Claims Tax each quarter. All PPACA Fees are the responsibility of the Employer (Plan Sponsor) to be submitted to the Federal government for payment.

I FURTHER ACKNOWLEDGE AND UNDERSTAND THIS IS NOT AN INSURED BENEFIT PLAN; All Plan benefits are self-funded (self-insured) by the employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form and all of its other requirements; Plan benefits are available only if a person is covered under and all required contributions for such coverage have been received by the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed; A full description of the medical expense benefits under the Plan appears in the Plan Document; The agent submitting this enrollment lacks authority to change the enrolment form, approve Plan coverage, alter Plan terms or adjust claims; the Employer has delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to SecureOne Benefit Administrators, Inc. a licensed third-party administrator; However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments. SecureOne Benefit Administrators, Inc. does not insure the Plan and is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who knowingly and with intent to defraud, submits and enrollment form or files a claim containing a materially false statement or omitting materially false information may be found guilty of fraud in a court of law, which if found guilty, may be terminated from the Plan, re-evaluation of rates to the employer or be reimbursed of all claims paid under the illegal act.

The Employer (Plan Sponsor) has explained to all employees that the coverage, if approved, becomes effective as of the effective date approved by the Preferred United Plans® "Alternative Funding"/SecureOne Benefit Administrators, Inc. coverage. The Employer (Plan Sponsor) understands that the agent does not have any authority to approve effective dates or to change, modify or cancel any coverage or conditions relating to coverage under the Employer (Plan Sponsor) plan under Preferred United Plans® "Alternative Funding" program.

The Employer (Plan Sponsor) agrees to submit the first month's fee with the Employer Application. All fees must be made payable to Preferred United Plans® "Alternative Funding" and must be paid.

Dated at _____, Michigan Dated on _____
City (Month, Day, Year)

Full Legal Name of Employer _____
Type or Print

Typed/printed name _____ Title _____

Signature _____

AGENT INFORMATION

Agent's Statement: I certify that all of the information contained in the Employer Application, the Employee Health Risk Assessment Applications and any attached contract papers are correct to the best of my knowledge. I have shown the "Alternative Funding" proposal, in its entirety, to the employer; with the complete understanding this is a self-funded program. I have fully explained the provisions of the "Alternative Funding" program and the benefits selected by the Employer (Plan Sponsor) as described by Preferred United Plans® "Alternative Funding" in its proposal. I know nothing unfavorable about this company or any individuals proposed for coverage. This firm is a bona fide business establishment. The employees applying meet the eligibility requirements and the compensation they receive is their main source of income. I have notified the Employer (Plan Sponsor) that their employees may be contacted by SecureOne Benefit Administrators, Inc. to verify information on their Employee Health Risk Assessment Application.

I certify that I have fully disclosed all information provided by Preferred United Plans® "Alternative Funding" and presented, in its entirety, the proposal to the employer (Plan Sponsor) and they fully understand this program is self-funded.

Licensed Agent Name _____

Agent Address _____

City _____ State _____ Zip Code _____

Agent Phone Number (_____) _____ Agent Fax Number (_____) _____

E-mail _____

Agent License Number _____ Agent Tax ID Number (Agent TIN) _____

Licensed Agent Signature _____ Date _____

Agency License Number _____

Agency Tax Identification Number (Agency TIN) _____

Agency Name _____

Agency Address _____

Agent Fee: ☐ **$15** ☐ **$20** ☐ **$25** ☐ **Other: $**_____