AmeriShare Field Underwriting Guide

AMERICAN TRUST
Administrators, Inc.
P.O. BOX 87 SHAWNEE MISSION, KS 66201

The purpose of this guide is to make your job easier and to help you get your client through ATA's acceptance process as quickly as possible. The more you know about how American Trust Administrators' Underwriting Department (ATA UW) conducts its business, the more positive your experience will be. When submitting a new group or when servicing a change on an existing group, certain basic underwriting guidelines should be followed to ensure good service for your client. This guide will address, in alphabetical order, a list of some of the more common practices associated with the ATA UW process. **This guide is effective on new business 09/01/12 and later and on renewal business 10/01/12 and later.**

To expedite the underwriting process, ATA Marketing Services will communicate directly with you to address your client's needs. In addition, ATA UW may communicate with the employee regarding medical information, and ATA Sales Enrollment may contact the group correspondent regarding missing or incomplete non-medical information in order to complete the enrollment process for you. Please contact ATA Marketing Services at the toll free number listed below if you have any questions or concerns. **All forms referenced in this guide are available at ATAAmerica.com.**

This document is intended merely as a guide and is not binding upon ATA or any insurance company issuing excess loss coverage. This guide does not contain all the guidelines utilized by ATA or the insurance company and is subject to change without notice. ATA and the insurance company will be solely responsible for applying these and the non-published guidelines. Their decision in this regard shall be final.

Important Telephone Numbers, Fax Numbers and E-mail Addresses

Contact	Telephone Number	Fax / E-mail Address
American Trust Administrators, Inc.	**(816) 251-7700** **Toll Free – 1-800-842-4121**	**Fax (816) 347-3600**
ATA Marketing Services	**(816) 251-7708** **Cell – (785) 331-7127** **(816) 251-7711**	**tom.stein@ataamerica.com** **patty.cranston@ataamerica.com**
ATA Administration	(816) 251-7768	rochelle.llamas@ataamerica.com
ATA Billing	(816) 251-7742	kathy.vadnais@ataamerica.com
ATA COBRA	(816) 251-7768	rochelle.llamas@ataamerica.com
ATA Customer Service - Claims	**1-800-843-4121**	
ATA Documents	(816) 251-7757	celeste.williams@ataamerica.com
ATA Eligibility	(816) 251-7720	candy.kling@ataamerica.com
ATA Licensing	(816) 251-7757	celeste.williams@ataamerica.com
ATA Underwriting	(816) 251-7738 (816) 251-7732	pam.troxel@ataamerica.com terri.grove@ataamerica.com
ATA Sales Enrollment	(816) 251-7738 (816) 251-7732	pam.troxel@ataamerica.com terri.grove@ataamerica.com
ATA 5500 Preparation Service	(816) 251-7757	celeste.williams@ataamerica.com
ATA Website	www.ATAAmerica.com	

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Actively At Work

Actively at work means the continuous actual performance of the customary duties designated by the company. If an eligible employee is not actively at work due to non-health reasons after the completion of the minimum waiting period, and before coverage begins, then another waiting period must be satisfied.

Agent Appointment, Solicitation and Licensing

ATA Compliance and your ATA Sales Representative will assist you with your appointment by the insurance company.

Please be advised that commissions and fees are paid only when you are properly licensed and appointed.

All agents must hold a valid license in their home state and in any other state where they solicit business. Some states require that the insurance company appoint you before you solicit. (Please see Agent Appointment and Solicitation Rules by State at the end of this guide).

To have unrestricted access to ATA's rating system you must complete an Agent Appointment Application (AAA) and attach a copy of your resident license. The AAA may be completed online at **www.ATAAmerica.com/AGENT_PORTAL.HTM**

Upon receipt of your AAA, we will send you a Request for Taxpayer Identification Form W-9 and a Compensation Agreement. We will require a copy of the Declaration Page from your E&O policy, but we will accept this information over the phone or completed on the AAA (**Please note, if you solicit business in Kansas, we must receive a copy of the Declaration Page from your E&O policy**).

Please note you must also submit a copy of your non-resident license if you solicit outside of your home state (please see Case Submission Process).

An Advertising Submission form is required if any of your advertising materials will contain the name American Trust Administrators, Inc., any of ATA's product names or insurance company name.

Benefit Changes/Plan Exceptions

Benefit changes are changes to the plan of benefits. For example, changing the employee deductible from $1000 to $2000. ATA UW reserves the right to disapprove any requested benefit change. A corporate officer of the company must sign-off on all benefit changes and rates before they will be implemented. Requests to change benefits must be received by ATA no later than the 10th of the month preceding the effective date of the change to ensure that 1) benefit changes are correctly reflected on the billing statement, and 2) claims are handled properly should the benefit change affect the way claims are paid.

Requests to increase life and AD&D insurance after case issue may require evidence of insurability and will be subject to ATA UW approval.

Plan exceptions are exceptions to the coverage provided under the plan. For example, the employer may request to cover a denied claim on a one-time basis or to cover an ineligible benefit for all employees all the time. ATA UW reserves the right to decline any requested plan exception and to decline excess loss coverage for any plan exception. A corporate officer of the company must request all plan exceptions in writing and sign-off on them before they will be implemented. On existing groups, approved plan exceptions will generally become effective the first of the month following such request. A rider may incorporate approved plan exceptions into the plan at issue or at renewal (please see Riders).

Any plan exception may be required to be funded outside of the plan by the employer and, as a result, will not be covered by the excess loss coverage.

The AmeriShare plan pre-empts state mandated benefits and, as a result, may not cover all state-mandated benefits. Requests to meet or exceed state-mandated benefits are not allowed because they are administratively prohibitive on a national basis.

Binder Checks

Acceptance letters are issued once ATA receives a binder check for 100% of the first month's cost (please see Case Submission Process). Binder checks are to be made payable to American Trust Administrators, Inc.

If the plan is *maximum funded*, binder checks should include the first month's fixed cost, plus the estimated monthly aggregate deductible, plus the fully insured costs, plus the one time set-up fee for aggregate run-in coverage, if elected. If the plan is *minimum funded*, the binder check should include the amounts listed above but it is recommended to include two month's estimated monthly aggregate deductible in order to establish an initial claims reserve to avoid claim payment delays (please see Funding).

Blended Rates

Blended rates are available on groups with multiple managed care plans and with different plans of benefits in different geographical areas. Separate sales proposals are required for each network and each plan of benefits. ATA UW will blend the rates. ATA UW will run sales proposals containing less than 10 covered medical employees.

Bonding Requirements

ERISA requires that the employer, as plan sponsor of an employee benefit plan, shall be bonded. The amount of the bond must be at least equal to 10% of the funds handled. However, it may not be less than $1,000. Existing fidelity bonds may be used to satisfy ERISA bonding requirements provided the amount of the bond is adequate to meet ERISA requirements, and it is clear the plan is covered by the bond. If it is not clear, a modification or separate agreement may be executed to clarify that the plan is covered. To obtain a fidelity bond, the plan sponsor should contact a commercial property/casualty agent.

Case Size

The minimum number of covered medical employees is 10. (Except for Minnesota minimum is 51, North Carolina minimum is 51, North Dakota minimum is 26 and Oregon minimum is 26.) This minimum must be maintained throughout the life of the plan. Groups falling below the minimum covered medical employees any time after issue have 90 days to bring the plan back to the minimum number of covered medical employees or the plan will be terminated at the end of the month following the 90-day period. With certain exceptions, the maximum number of covered medical employees at issue is 99.

Case Submission Process

The following guidelines are intended to facilitate rapid underwriting turnaround, and allows us to issue ID cards to the covered persons on or before their effective date. Discretion will be used when applying these guidelines based on the quality of the case submission.

A copy of your resident and/or non-resident license and agency license, if applicable, must accompany your first case submission to be accepted by ATA. (Please see Agent Appointment, Solicitation and Licensing).

The six key items below must be received by ATA Marketing Services at least 10 calendar days preceding the requested effective month (or the next following work day) or the requested effective date may be moved to the next following month.

1. Fully Executed *Preliminary Employer Application.* **This application will not be accepted if it is more than 60 calendar days old from the requested effective date**.

2. Fully Executed *Employee Enrollment/Refusal Forms* for all eligible employees (including employees waiving coverage and newly hired employees in their waiting period) persons on COBRA, and persons in their COBRA election period. Employees waiving medical coverage are not required to complete the Health Statement Section.

This form will not be accepted if it is more than 60 calendar days old from the requested effective date.

3. A *Billing Statement* from the current health provider for the month prior to the requested effective month as well as a *Billing statement* from the corresponding period from a year ago (used to expedite credible coverage).

4. The most recent *Quarterly Wage and Tax Report* for all companies and locations. Also, proof of earnings is required for any eligible employees not on the most recent report. This report must include the cover page showing the legal company name, address, and federal identification number (please also see Eligible Employees and Dependents).

5. The sold *ATA Sales Proposal*(s).

6. Current *Schedule of Benefits*.

(Please see Professional Employer Organizations for additional information required on groups utilizing such services).

ATA Marketing Services will review this material for completeness and work directly with you to obtain missing and/or incomplete information before forwarding the case to ATA UW. **Your ability to collect complete and accurate information and to submit this information timely is essential to ensure the requested effective date**.

ATA UW will underwrite the case for group eligibility, ownership, participation and medical risk. ATA Marketing Services will send you (first) and the group (second) one of the following:

Standard Sales Offer

A standard sales offer will be made without larger individual specific deductibles at standard rates if there are no major, ongoing health conditions.

Alternative Sales Offer

An alternative sales offer will be made with larger individual specific deductibles and/or higher group rates if there are medical conditions that ATA UW believes can be managed by larger individual specific deductibles and/or higher group rates.

Decline

No sales offer will be made if medical conditions are expected to exceed reasonable net annual specific premiums or a reasonable annual aggregate deductible amount.

Generally, groups of 50 or more covered medical employees with individuals who are not expected to fully recover from their medical conditions will be candidates for larger individual specific deductibles or these may result in the declination of the group.

After review and acceptance of the proposal, the group must submit to ATA Marketing Services a **fully executed Enrollment Request and, if applicable an executed Individual Specific Deductible Acceptance Form.**

ATA Sales Enrollment will work directly with the group correspondent and will send the following documents to the group for final execution:

1. The Employer Application

2. The Employer's Trust Agreement (establishing a trust for the plan assets)

3. The Employer/ATA Service Agreement (establishing each parties duties)

The three items above and a check for 100% of the first month's cost payable to American Trust Administrators, Inc., must be received by ATA Sales Enrollment on or before the requested effective date (or the next following work day) or the requested effective date may be moved to the next following month. ATA Sales Enrollment will issue you and the group an acceptance letter after receiving these three items and check.

PLEASE INSTRUCT YOUR CLIENT NOT TO CANCEL THEIR CURRENT COVERAGE UNTIL THEY HAVE RECEIVED AN ACCEPTANCE LETTER FROM ATA SALES ENROLLMENT.

ATA Administration will send Employee identification cards and a Service Manual to the group within 5 working days of group acceptance and receipt of the binder check. The Service Manual contains instructions and forms to guide the employer on the administration of this plan. You may obtain a copy of the Service Manual from ATA Administration or from our website.

Classes of Employees

Employee classes may be established on fully insured life and AD&D and weekly income benefits. It is important to clearly define and describe each class using the actual occupational titles included under each class.

For example, class A may include "Eligible Owners and Officers", class B may include "Eligible Managers and Supervisors", and class C may include "All Other Eligible Employees". Describing classes using the terms "Salaried and Non-Salaried" is not acceptable because these are not occupational titles. Classes defined by years of service are also not acceptable.

COBRA

Federal law requires certain employers to provide continuation of coverage to certain individuals upon the occurrence of a qualifying event.

Employers subject to this law include those employing 20 or more employees, including full-time and part-time employees, on at least 50% of its workdays during the preceding calendar year (part-time employees are counted as a fraction of their working hours divided by the number of hours the employer considers full-time).

Groups with between 17 and 23 total employees may be required to submit Quarterly Wage Reports for the preceding calendar year's four quarters so that ATA COBRA can determine if this law applies. The following events are qualifying events under COBRA law.

1. A Voluntary or Involuntary Termination
2. A Reduction in Hours Worked
3. The Death of an Employee
4. A Dependent Child Ceasing to be Eligible under the Plan
5. A Divorce or Legal Separation
6. The Employee Becomes Entitled to Medicare Benefits

ATA provides the COBRA Notification Service to all groups subject to COBRA. Groups will not be permitted to provide their own COBRA notification to individuals who experience a qualifying event under this plan.

Groups must notify ATA within 30 days of a qualifying event using **COBRA FORM A**.

ATA will send the required notices and election forms within the required time frames, maintain a record of all statutory time requirements, and notify the group of all persons who properly elect COBRA.

The COBRA premium will be equal to 102% (or 150% if disabled) of the applicable premium. ATA will calculate suggested applicable premium and send notice of these premiums to new and renewal groups for their approval. ATA will retain 2% of the applicable premium as an administrative fee. ATA will bill COBRA persons the COBRA premium directly, at the most current address reported to ATA by the plan administrator. The employer's bill will continue to reflect the full cost of coverage as if the person was an employee. On maximum funded groups (please see Funding), the employer will receive a credit, up to the total amount billed for claims, for the entire amount of the collected COBRA premium, less ATA's administration fee. This will appear as a credit on the employer's monthly bill. The COBRA premium collected from COBRA individuals, less ATA's administrative fee, will be credited to the employer's reserve account.

ATA will send each group an **Annual COBRA Verification Form** in November of each year to determine if the group is subject to COBRA in the following calendar year. COBRA continuation will not be provided to any group that does not return this form in a timely manner.

Commissions and Fees

Commissions and fees are paid only when you are properly licensed and appointed (Please see Agent Appointment, Solicitation and Licensing).

Commissions and fees are paid on the 10th of each month on amounts collected as of the end of the previous month. Commission is paid on **total fixed cost** and the cost of fully insured benefits. Commission percentages may be split between Agents. In addition to commission percentages, medical fixed cost may be loaded with a flat fee per employee per month; these fees are also commissionable, and may be split between Agents.

All Agent compensation must be disclosed to the employer on the Service Agreement and all Agents receiving any compensation must be listed on the Service Agreement.

Common Law Marriage

Although a marriage license and ceremony are generally required as proof of marriage, the following states still recognize what is known as a "common-law" marriage: AL, CO, DC, GA (before 1/97), ID (before 1/96), IA, KS, MT, OH (before 10/91), OK, PA (before 9/03), RI, SC, TX and UT. In these states, ATA UW will require a **Common Law Marriage Form** for consideration of dependent coverage; otherwise the partner may not be eligible for spousal coverage. Some states may recognize out-of-state common law marriage. Contact ATA Sales Enrollment for a list of these states.

Contract Wording

The specific and aggregate excess loss contracts contain incurred and paid claim wording. For example, 12/15 means the contract will cover eligible claims incurred in the 12-month liability period and paid within the liability period or the following 3 months.

The following table lists the specific and aggregate excess loss contracts offered during the first year and renewal years of a contract.

Specific			Aggregate	
FY	**RN**		**FY**	**RN**
12/12	24/12		12/12	24/12
12/15	12/15		12/15	12/15
12/18	12/18		12/18	12/18
			15/12	24/12

Groups electing 12/12 specific coverage and/or specific only coverage (no aggregate coverage) will be required to submit an Acknowledgement of Understanding stating that they understand and accept the potential additional liability associated with such plans upon termination.

Groups electing 12/12 or 15/12 aggregate coverage the first year are automatically enrolled in aggregate terminal liability coverage. The coverage becomes active 1) upon termination, as long as the termination is at the end of the contract period, and 2), upon timely receipt by ATA of the premium and any fees due for the terminal liability coverage. Under this coverage, eligible charges incurred prior to the end of the contract and paid within 3 months after the end of the liability period will be covered under a separate aggregate deductible. This coverage does not cover losses in excess of the specific deductible. Premiums and fees for this coverage are due upon termination.

Groups electing 15/12 aggregate coverage the first year have limited aggregate run-in coverage. Under this coverage, eligible charges under this plan incurred in the 90-day period immediately preceding the liability period will be covered under the aggregate excess loss policy. Such charges are subject to a dollar limit stated in the sales proposal.

There is an additional one-time charge of $30 per employee for aggregate run-in coverage. ATA UW must be provided a report showing the amounts satisfied under the deductible and out-of-pocket due to coinsurance for each individual during the current calendar year. ATA Sales Enrollment will assist you with obtaining these reports. Specific run-in coverage is not available.

Aggregate terminal liability coverage is not available if the plan terminates before the end of the 12-month liability period.

Contribution and Participation

Non-Contributory Plans: If the employer pays 100% of the cost of any coverage for the employee and/or dependents, then all eligible employees and dependents must enroll in that coverage even if they have similar coverage elsewhere.

Contributory Plans: If the Employer requires employees to pay any part of the cost of any coverage, then 75% of total eligible employees and 75% of total eligible dependents must enroll in that coverage. For this calculation, total eligible employees and dependents exclude persons with similar coverage elsewhere, persons in their waiting period, persons on COBRA, and persons in their COBRA election period. However, at least 50% of eligible employees, including those with similar coverage elsewhere, must be enrolled at all times.

Please consider the following example. Eligible employees work 30 or more hrs/week.

50% Test

52 eligible employees excluding COBRA
50 less 2 employees in their waiting period
25 times 50% (minimum number of employees that must be covered)

75% Test

52 eligible employees excluding COBRA
50 less 2 employees in their waiting period
40 less 10 employees with other coverage
30 times 75% (30 is greater than 25 above so this case would pass participation)

ATA UW realizes there may be some groups at issue that fall below the employee and/or dependent participation requirements by one or two lives. In these cases, an exception may be made, and the employee and/or dependent premium rates and aggregate attachment factors may be loaded. Discretion will be applied if the group meets medical participation but fails dental and/or vision.

Contribution – Excess Loss Coverage: Because the excess loss policy covers the employer and not the employer's plan, *payment of excess loss premiums must be made solely from the employer's general account and should not be made from any account containing plan assets or employee contributions.* As a result, and to simplify this requirement under this plan, the employer must contribute 100% of the employee and dependent health plan fixed cost. The employer must also contribute at least 25% of the cost of any life, accidental death & dismemberment, and weekly indemnity insurance.

Coverage Rules (Employee and Dependent)

Coverage here means employee and dependent medical, dental, vision, life, accidental death & dismemberment (AD&D), and weekly indemnity coverage.

The employee must first elect a coverage before his/her dependents are eligible for that same coverage.

An individual cannot be covered under the plan simultaneously as an employee and as a dependent, nor as a dependent of more than one employee.

Employees within the same group who are married to each other may elect the coverage and rate structure that best fits their needs.

Under contributory plans, the employee may refuse a coverage, or all coverages, as long as group participation is met for each line of coverage. However, an employee cannot refuse life and AD&D coverage if that employee elects medical, dental and/or vision coverage (Please see Optional Benefits).

Discriminatory Plans

Discriminatory plans are ineligible. Highly compensated individuals and all other individuals must be provided the same eligibility to participate in the plan and the same benefits under the plan, otherwise the plan is discriminatory. A highly compensated individual is any individual who is (1) one of the five highest paid officers of the company, (2) a shareholder who owns, directly or indirectly, more than 10% in value of the stock of the employer, or (3) among the highest paid 25% of all employees.

However, this plan may exclude eligible individuals under the following conditions:

1. Bona fide classes of employees are established at issue. For example, Salaried/Hourly or Union/Non-Union or Management/Non-Management.

2. A letter of understanding is obtained from the plan sponsor recognizing that the plan may be discriminatory.

3. A minimum of 35% of total eligible employees, including those to be excluded, must be enrolled in this plan.

It is a violation of Federal Tax Law for self-funded plans to set the minimum number of hours worked per week higher than 35 hours for full-time employee status.

Waiting periods varying by class of employee are discriminatory on the medical plan.

Domestic Partner Coverage

Domestic partner benefits are benefits that an employer voluntarily chooses to offer to an employee's unmarried partner, of the same or opposite sex.

An employer wishing to implement coverage for domestic partners needs to first identify what constitutes a domestic partner. The most common definition contains several core elements:

1. The partners must have attained a minimum age, usually 18
2. Neither person is related by blood closer than permitted by state law of marriage
3. The partners must share a committed and exclusive relationship
4. The partners must be financially interdependent

The employer must also decide whether the domestic partner program is to cover same-sex couples only or include opposite-sex couples. A written request from the employer to ATA is required to offer domestic partner coverage. A rider to their plan may be required.

Dual Health Plans

This plan must be the only health insurance plan offered by the employer. However, two plans of benefits may be offered to employees in the same group.

There is no minimum number of employees required in each plan but the dependents must enroll in the employee's plan. Rates for each plan are loaded 4% if dual plans are offered.

Cross enrollments between plans may only be made on plan anniversary dates. The cross-enrollment period will run from the 1st through the 15th of the month two months prior to the plan anniversary. Changes would be required to be reported to us no later than the first of the month preceding the plan anniversary. For example, given a 1/1 plan anniversary, plan changes could be elected (signed enrollment form) from 11/1 through 11/15 and must be reported (received date) to us no later than 12/1.

Effective Dates (Employees and Dependents)

Employers may choose one of two options for employee and dependent effective dates. The "1st of the Month Following" option means eligible employees and dependents will become eligible for coverage **on the first of the month following** the satisfaction of the group's waiting period. The "Immediately Following" option means eligible employees and dependents will become eligible for coverage **on the first day following** the satisfaction of the group's waiting period.

Please consider the following examples of employee effective dates.

1st of the Month Following

12/15 Date of Full Time Employment
1/1 Group Effective Date
1 Month Group Waiting Period
Eligible for Coverage on 2/1

Immediately Following

12/15 Date of Full Time Employment
1/1 Group Effective Date
1 Month Group Waiting Period
Eligible for Coverage on 1/16

Under the "Immediately Following" option, employees and dependents effective between the 1st and 15th of the month will be charged a full month's cost for the partial month. Employees and dependents effective between the 16th and the end of the month will not be charged for the partial month.

Under both options, the employee has 30 days from the date the employee is eligible for coverage (2/1 or 1/16 in the above examples), to sign the **Employee Enrollment/Refusal Form** and 52 days from the same date for it to be received by ATA UW; otherwise the employee and/or dependent will be considered a Late Entrant (please see Late Entrants).

Effective Dates (Groups)

The group effective date will generally be the 1st of the month unless the group had a mid-month effective date with the prior carrier (in which case ATA UW will honor a mid-month effective date). Mid-month effective dates will be renewed one year after the 1st of the next month. The first month's cost will be pro-rated for the number of days of coverage during the first month.
There is no coverage until ATA UW assigns and approves a group's effective date and the group should never cancel their current coverage until they receive written acceptance from ATA Sales Enrollment. A group may request in writing to change their effective date prior to acceptance. ATA UW reserves the right to move the group's effective date and change rates before written acceptance is provided. However, the effective date will not be changed once a group receives written acceptance and an effective date from ATA Sales Enrollment.

Eligible Employees and Dependents

Eligible employees are those employees listed on the Employer's Quarterly Wage Report who are full time employees working for a salary or wage at least 30 hours per week or 120 hours per month. Persons on COBRA and persons in their COBRA election period are also eligible. Retirees and independent contractors (1099 recipients) are not eligible. Owners and partners not listed on the Quarterly Wage Report will be required to provide a **Verification of Employment Form,** which may allow the plan to be amended to allow them to be covered. Eligible employees, COBRA persons, and owners and partners must have a Social Security number.

Eligible dependents are the employee's legally married opposite-sexed spouse and the employee's unmarried naturally born children, stepchildren, or legally adopted children. Dependent children must be less than 26 years of age. A legally adopted child will be considered acquired on the earlier of (1) the date the legal adoption document declares the adoption to be final, or (2) the date that court papers indicate the child is placed for adoption in the employee's home. Parents, grandchildren, nieces, and nephews are not eligible dependents (unless legally adopted).

An enrollment request for a newly acquired dependent or a dependent becoming eligible after the Employee's effective date must be submitted timely by a fully completed **Employee Enrollment/Refusal Form or Change Form**. The form must be signed within 30 days of the event causing the new eligibility (for example, marriage or adoption) and received by ATA Eligibility within 52 days of the event. Otherwise, the dependent will be considered a Late Entrant. (Please see Late Entrants).

Notification of an employee's **first covered newborn** must be submitted timely using a **Change Form or Employee Enrollment/ Refusal Form** and must be signed within 30 days of birth and received by ATA Eligibility within 52 days of birth, otherwise the newborn will be considered a Late Entrant (please see Late Entrants). **Second and subsequent covered newborns must still submit a Change Form or Employee Enrollment/Refusal Form** but will not be held to the notification time requirements of the first covered newborn.

Eligible employees and their dependents must be resident citizens of the USA or legal aliens with legal permission to reside and work in the USA. A copy of their Alien Registration Card(s) and/or legal work permit must be attached to the **Employee Enrollment/Refusal Form** at the time of submission.

Employee Enrollment/Refusal Form

Instructions for the employee to complete this form are listed at the top of this form. Employees, and not sales personnel, must fully complete this form. **Your ability to collect complete and accurate information and to submit this information timely is essential to ensure the group's requested effective date. Incomplete, illegible, and improperly altered forms will delay the underwriting process and jeopardize the requested effective date.**

This form must be fully completed (including the Health Statement Section) by all eligible employees electing medical coverage or life only coverage, including newly hired employees in their waiting period, persons on COBRA, and persons in their COBRA election period. This form must be completed by all otherwise eligible employees refusing coverage, excluding the Health Statement Section.

On new groups, ATA UW reserves the right to underwrite and retroactively change rates and/or place higher individual specific deductibles on individuals hired before the group's effective date if their Enrollment/Refusal Forms are received after written acceptance has been given.

If any person refuses to complete this form, including the Health Statement Section, or refuses to complete the telephone medical interview, the group's premiums and aggregate factors may be loaded, or the group may be declined.

Eligible married employees must each complete an Employee Enrollment/Refusal Form if they both want employee life benefits, even if one employee may be enrolling as a dependent of the other.

Employees electing life only coverage must fully complete this form (including the Health Statement Section).

The Employee Enrollment/Refusal Form must be dated using the date it is completed by the employee. Employee Enrollment/Refusal Forms dated more than 60 calendar days from the requested effective date must be re-signed and dated by the employee, verifying that all information on the form is accurate and up-to-date.

Enrollment Request

Along with the sales proposal that you receive from ATA, you will receive a form entitled "Enrollment Request". This form contains pertinent information regarding the employer, coverage(s) they are selecting and your agency information. Please complete the section entitled "Agent/Agency".

An owner, corporate officer, or partner of the company must carefully review and complete this form. Such individual must sign, currently date and return the form to ATA in order for us to begin the installation process.

Form 5500

Form 5500 may be required to be filed with the Department of Labor for each plan year. ATA will prepare the required **Annual Form 5500** based on information provided from each group and data captured by ATA. This service is only provided for groups with under 100 participants and only for this plan. The cost for this service is included in the fixed cost shown in the sales proposal.

Funding (Self-Funded Claims Account)

Groups may elect one of two methods to fund their claims account: maximum funding or minimum funding.

Under the maximum funding option, the group funds the monthly aggregate deductible shown on their monthly bill and this amount is credited to their claims account.

Under the minimum funding option, the group will make periodic deposits to their claims account as needed to fund claims. **It is recommended that new groups deposit at least two months' estimated monthly aggregate deductible in their claims account the first month to establish a beginning reserve**. Processed claims will be held if there are insufficient funds in the claims account to cover such claims, and the group will be sent an Interim Bill advising the amount needed to release the held claims.

Under both funding methods, the group may be required to fund amounts in addition to their maximum claim liability for the following reasons: 1) Individual specific deductibles, 2) excluded claims, and 3) if the group falls below the minimum monthly or minimum annual aggregate deductible.

Interest earned on money in the claims account is credited to the plan. Excess money in a claims account is a plan asset and may be released upon written request from a corporate officer of the group. Plan assets can only be used for providing employee welfare benefits.

Requests to change from one funding method to another must be made by the group in writing and received by ATA Billing 30 calendar days prior to the requested change date. Change requests received after 30 days prior to the requested change date, will become effective the 1st of the following month.

Generally, without actuarial certification, the claims account reserve for any taxable year may not exceed 35% of the cost, excluding premiums, for the immediately preceding calendar year. For example, if an employer's cost for medical benefits was $200,000 in year one then the year two reserve limit is $70,000 (35% of $200,000). If the year 2 actual costs were only $50,000, then the year 3 reserve limit would drop to $17,500 (35% of $50,000).

Indication Process

The purpose of the Indication Process is to provide a preliminary rate load factor based on the information submitted on the Indication Questionnaire, before any applications are taken and/or medical telephone interviews are conducted (please see Telephone Medical Interviews).

A complete sales proposal, including the census and quote data page, must be submitted. An *Indication Questionnaire* (or similar type of information contained in the Indication Questionnaire) must be submitted. This questionnaire asks for the following information on all persons requesting medical coverage:

1. The employee's name
2. The employee's and spouse's date of birth
3. The employee's and spouse's height and weight
4. Whether or not the employee and spouse use tobacco products
5. The medical condition(s), and
6. Details on the medical condition(s).

Once ATA Sales & Marketing receives this information and reviews it for completeness, they will forward it to ATA Underwriting. ATA Sales & Marketing will send you a quote with the resulting rate loads, if applicable, within five working days.

The indication outcome will be based on the amount and detail of information provided on the Indication Questionnaires (or reasonable facsimile of information). The indication process does not replace the standard new case submission process. Fully completed Enrollment/Refusal forms are required to provide final costs.

Individual Specific Deductibles

In lieu of a standard sales offer, ATA UW may place deductibles on certain individuals (due to their health condition), that are larger than the specific deductible elected by the employer.

The amount up to the employer's specific deductible will apply to the annual aggregate deductible. The amount exceeding the employer's specific deductible and less than the individual specific deductible will not apply to the annual aggregate deductible and is the employer's liability.

The amount exceeding the employer's specific deductible must be satisfied independently of, and will not be applied toward satisfying, each individual's respective specific family deductible amount.

ATA UW will apply discretion on an individual basis when determining whether or not the individual specific deductible will be condition-specific and if it will include or exclude accidental injuries.

ATA UW must receive and evaluate all requested medical information before individual specific deductibles will be set and offered. No open-ended or "blind" individual specific deductibles will be offered. The group will not receive an acceptance letter until a corporate officer of the company signs and returns the **Individual Specific Deductible Acceptance Form**.

ATA UW will review the removal or reduction of individual specific deductibles at renewal upon written request from a corporate officer of the company.

Individual specific deductibles will not be placed on individuals as a condition of renewal, however may be offered as a renewal option.

Industry

The Rating System requires Standard Industry Classification (SIC – 4 digits). It will also accept North American Industry Classification System (NAICS – 6 digits).

The NAICS six-digit code (formerly SIC), can be found on the following Internal Revenue Service Tax Returns :

Form 1040, U.S. Individual Tax Return, Schedule C – Page 1, **Box B**

Form 1065, U.S. Partnership Return of Income, including LLC's – Page 1, **Box C**

Form 1120S, U.S. Income Tax Return for an S Corporation – Page 1, **Box B**

Form 1120, U.S. Corporation Income Tax Return, – Page 3, Schedule K - **Question 2a**

Form 990-T, Exempt Organization Business Income Tax Return, – Page 1, **Box E**

An exempt organization filing form 990, Return of an Organization Exempt from Income Tax, should provide the information from Page 1, **Box J**.

If you are not able to locate the SIC for a company, you may contact your ATA Sales Representative. They will access the Dun & Bradstreet web site and provide you with one.

Sales proposals submitted with SIC of "9999" or industries containing "Not Elsewhere Classifiable – NEC" will be subject to final ATA Underwriting approval.

Employers with the following characteristics **are not eligible**. Any industry determined by ATA Underwriting to be similar in nature or kind may not be eligible.

Ineligible Industries/Employers

Employee Leasing and Temporary Help (Please see Professional Employer Organizations)

Employers without an employer/employee relationship

Employers considered to be Multiple Employer Welfare Associations

Employers not meeting the minimum Contribution and Participation requirements

Employers with 40% or more annual employee turnover (This applies only to Non-Preferred Class I and Class II Industries)

Non-ERISA plans (Public Schools, Churches, and County, City, State, and Other Governmental Entities

Non-ERISA plans are ineligible because they may have to comply with state mandated benefits and such plans are prohibitive to administer on a national basis.

Union-only plans are ineligible but plans containing union and non-union employees are eligible if the union contract date is the same as this plan's effective date. This will permit union plan changes to coincide with this plan's renewal date (please see Benefit Changes).

Late Entrants

All requests to add eligible employees and/or dependents (for example, a newly hired employee or newly acquired dependent) must be done timely or the individual will be considered a Late Entrant and will be subject to a 6 month waiting period. No coverage will be provided

during the waiting period and the individual will not be charged a premium.

Timely means the eligible employee must sign and date the **Employee Enrollment/Refusal Form or the Change Form** within 30 calendar days of the date the employee first becomes eligible for coverage. In addition, the request for coverage must be received by ATA Eligibility within 52 calendar days from the date the employee first becomes eligible for coverage.

In the case of a dependent, an enrollment request for a newly acquired dependent or a dependent becoming eligible after the employee's effective date must be submitted timely by a fully completed **Employee Enrollment/Refusal Form or the Change Form.** The form must be signed within 30 days of the event causing the new eligibility (for example, marriage or adoption) and received by ATA Eligibility within 52 days of the event.

Leased Employees

Leased employees are not eligible employees under the plan (please see Professional Employer Organizations).

Legal Separation/Divorce

Legally separated and divorced spouses are not eligible. An exception may be made if ATA UW is provided the court documentation indicating that the court orders coverage for that spouse. ATA UW reserves the right to disapprove such exceptions.

Life and AD&D Insurance

Life and AD&D insurance is provided on a fully-insured basis. A minimum benefit of $15,000 is required for all employees electing medical, dental and/or vision coverage (except in Florida and Wisconsin where the employer is not required to elect this coverage). The employee can refuse this coverage under contributory plans only if the employee refuses all other coverages and if this benefit meets required Participation. The maximum benefit issued is $50,000. This benefit may not be approved for sale in all states (please reference the Rating System to see if this benefit is available in the group's state).

Employee life and AD&D benefits can be a flat amount or a percentage of annual salary. If this benefit is a percentage of annual salary, then the group must provide ATA UW a list of current salaries during the underwriting process and at each policy anniversary date thereafter. Benefits will reduce by 35% at age 65 and an additional 25% at age 80.

Dependent life benefits are optional to the group. The dependent spouse life benefit can range from $1,000 to $5,000 by increments of $1,000. The dependent child life benefit is 5% of the spouse life benefit from 10 days to under 6 months old and 50% of the spouse life benefit from 6 months to under 19 years old (or under 23 years old if a full-time student).

All life and AD&D benefits include occupational coverage. ATA UW reserves the right to disapprove life and/or AD&D benefits. Groups requesting life only benefits (no medical coverage) are not eligible.

Employees electing life-only coverage will be medically underwritten.

Evidence of insurability is required on Late Entrants requesting life coverage and may also be required on requests to increase life coverage after issue. Such individuals are subject to final ATA UW approval.

Non-medical issue amounts are shown in the following table and vary by the number of medical employees enrolled at issue. Amounts exceeding the non-medical issue amount may require a paramedical exam.

Number of Medical Employees Enrolled at Issue	Non-Medical Issue
10 to 24	Lesser of $50,000 or 2 times the average certificate amount
25 to 99	$50,000

Managed Care Networks

Managed care networks provide a means to control costs, and ATA UW encourages their sale and usage. More than one network can be offered on the same group. Only one network, however, is allowed within the same geographical

area. A minimum benefit differential between in- and out-of-network may be required on some networks.

ATA UW should be provided a sales proposal for each network within a group, containing the eligible employees and dependents enrolling in each network. ATA UW will run sales proposals containing less than 10 covered medical employees because the Rating System will not allow you to run such proposals in the field.

If, at the time of quote, it is not known in which network each employee will enroll, a sales proposal containing all eligible employees and dependents should be run using the network with the most employees. Please indicate on the sales proposal the other networks the group is electing. ATA UW must approve and blend rates for multiple networks for a group.

Eligible employees and dependents residing outside of the group's managed care network service area may elect an office visit co-pay benefit. This benefit is not available, however, to groups with more than 30% of their total covered medical employees residing outside of the managed care network service area.

Maternity

Federal law mandates that employers must provide maternity coverage if that employer employs 15 or more full-time and part-time employees for 20 or more weeks in either the current or preceding calendar year. Maternity is optional under this plan on groups with less than 15 total employees. Maternity covers employees and spouses and their newborns only and does not cover dependent children and their newborns. COBRA persons do have maternity coverage. Adding this benefit after issue must be approved by ATA UW and will only be considered on policy anniversary dates. Complications due to maternity are covered the same as any other illness.

Medical Conversion

An employee or dependent spouse who has had medical coverage under this plan for at least 6 consecutive months, who is not eligible for Medicare or COBRA, whose medical coverage ceases because employment has been terminated or because there has been a change in marital status, will be entitled to a medical conversion policy issued by an insurance company.

The cost for this entitlement to elect a medical conversion policy is included in the fixed costs shown in the sales proposal. Eligible persons requesting this coverage should contact ATA COBRA for enrollment materials.

Medical Underwriting

In addition to assessing a group's ownership and participation, ATA UW must determine the medical risk. To accomplish this, ATA UW will rely on the **Employee Enrollment/Refusal Form**, telephone medical interviews and, when necessary, attending physician statements and medical records.

The success of this process will depend primarily on your ability to timely secure a complete and accurate Employee Enrollment/Refusal Form.

ATA UW will prepare one of the following depending upon the results of medical and non-medical underwriting.

Standard Sales Offer

A standard sales offer will be made without larger individual specific deductibles at standard rates if there are no major, ongoing health conditions.

Alternative Sales Offer

An alternative sales offer will be made with larger individual specific deductibles and/or higher group rates if there are medical conditions that ATA UW believes can be managed by larger individual specific deductibles and/or higher group rates.

Decline

No sales offer will be made if medical conditions are expected to exceed reasonable net annual specific premiums or a reasonable annual aggregate deductible amount.

Groups with individuals who are not expected to fully recover from their medical conditions will be candidates for larger individual specific

deductibles or these may result in the declination of the group.

Medicare Primary/Secondary

This plan is secondary to Medicare whenever by law it may be secondary. The following are the basic rules: 1) If the employer employs more than 20 full-time and part-time employees for 20 or more weeks in either the current or preceding calendar year then this plan is primary to Medicare (unless the Medicare beneficiary is covered because they have End Stage Renal Disease (ESRD)). 2) If the Medicare beneficiary is receiving Medicare due to disability (other than ESRD), then this plan will be primary as long as the employer had over 100 full-time and part-time employees on 50% or more of its business days during the preceding calendar year. 3) If the Medicare beneficiary is receiving Medicare due to ESRD then Medicare is secondary for the first 30 months after commencement of the statutory waiting period.

In order for Medicare to be primary under either paragraph 1 or 2 above, the Medicare recipient must have coverage under this plan by virtue of the employee's current employment status. In determining whether the 20 or 100 person tests have been met, there are special aggregation rules set forth in the Internal Revenue Code.

Groups with between 17 and 23 total employees may be required to submit Quarterly Wage Reports for the preceding calendar year's four quarters in order for ATA UW to determine how this plan coordinates with Medicare.

Minimum Age

Generally, employees under 18 years old are not eligible under the plan. However, an employee under 18 years old may be eligible if the employee can provide court documentation declaring themselves emancipated. Employees turning 18 after the plan effective date must submit an **Employee Enrollment/Refusal Form or Change Form** within 30 days of their 18th birthday and it must be received by ATA Eligibility within 52 days of their 18th birthday or they will be considered a Late Entrant and subject to a 6 month waiting period (please see Late Entrants).

Name and Address Changes (Group)

Group name and/or address changes must be submitted in writing to ATA along with the reason(s) for the change. Examples include a group name change only versus a company name change as a result of a company merger or sale; or a change of mailing address only versus a change of address as a result of a physical move.

New York Health Care Reform Act

New York requires all group health plans, whether domiciled in New York or out-of-state, to pay a surcharge on certain claims paid on behalf of its employees and dependents. This plan is not approved for sale in New York, however all groups with employees that could obtain health care services in New York must complete and return to ATA Sales Enrollment the **New York Surcharge Forms**.

Open Enrollment Periods

Open enrollment periods are only allowed under this plan for dual health plans (please see Dual Health Plans, Effective Dates, Late Entrants and Waiting Period).

Optional Benefits

Dental, vision and weekly indemnity insurance are optional benefits under the plan (life and AD&D is required on all groups except in WI and FL).

Life and AD&D and weekly indemnity insurance are provided on a fully insured basis. Dental, prescription drug and vision benefits are provided on a self-funded basis and apply toward the specific and aggregate coverage the same as medical. Prescription drug coverage cannot be carved out of the medical plan.

Dental, and vision benefits are also offered on an ASO basis and may be added to the plan off-anniversary the 1st of the month following receipt of written authorization from an officer of the company. Participation requirements will not be imposed on ASO benefits.

The cost of ASO services is shown in the following two tables. ASO services are less

expensive when sold with excess loss coverage vs. stand alone. ATA also offers customized ASO quotes. The Claim fee referenced below is 5% and waived With Excess Loss on groups with 50 or more medical premium paying employees.

With Excess Loss	Cost
Dental	$5 pepm plus claim fee
Vision	$3 pepm plus claim fee

Stand-Alone	Cost
Dental	$8 pepm plus claim fee
Vision	$5 pepm plus claim fee

Ownership

A self-funded welfare benefit plan (this plan) can only cover employees of one employer; otherwise the Department of Labor may deem the plan to be a multiple employer welfare arrangement (MEWA).

MEWA's are not eligible under this plan because they are not legal in some states and because the employer would have to pay for benefits mandated by state law that may be excluded under the specific and aggregate coverage.

However, more than one employer may be considered a single employer if they can demonstrate a sufficient degree of common ownership. The **ATA Ownership Form** must be completely filled out to determine common ownership.

Common ownership means the owners must demonstrate a controlling interest of at least 80% and an effective control of more than 50%.

To demonstrate effective control of all companies to be covered, sum the smallest percentage that each person owns of any of the companies, including all persons that own any percentage of the companies. The same 5 or fewer persons must meet the effective control test for each company (there cannot be more than 5). Persons owning 0% of any company are excluded.

To demonstrate a controlling interest for each company to be covered, sum the percentage ownership of all owners in each company but only for those owners used in determining effective control.

Under certain circumstances, the owners of certain interests may be added together before the tests are run. Some examples are that spouses may add their interests and minor children may add their interests to those of parents or grandparents.

Consider the following example of three owners of two companies that can demonstrate both effective control and a controlling interest.

	Company		**Effective Control**
Owner	A	B	
# 1	~~20%~~	~~0%~~	~~0%~~
# 2	40%	50%	40%
# 3	40%	50%	40%
	80%	**100%**	**80%**
	Controlling Interest		

In the above example, owner #1 is removed from both tests because he has no ownership in Company B. Owners #2 and #3 have 80% effective control which exceeds the "greater than 50%" required. Owners #2 and #3 also have an 80% controlling interest in Company A, and a 100% controlling interest in Company B, which both exceed the "80% or greater" required. As a result, these two companies have common ownership and may be written under a single plan.

If a group cannot meet ownership guidelines, then it may be possible to write the company or companies under separate plans. However, each plan must have at least 10 covered medical employees or the plan cannot be written.

If an existing group purchases a branch location and maintains the same Federal Identification Number, then the branch location will be added and the new employees will be subject to the group's waiting period, which will begin from the date of purchase. Evidence of insurability will only be required if the new employees request immediate coverage, i.e. request to waive the waiting period.

If there is an Affiliate/Subsidiary purchase that causes an existing group to change their Federal Tax Identification Number then: 1) the group must meet common ownership guidelines 2) evidence of insurability will be required on all new employees and dependents 3) premium rates and aggregate attachment factors will be subject to change, and 4) the new addition(s) is subject to final ATA UW approval.

If an existing group sells its assets, as opposed to selling its stock, then this plan will terminate and ATA UW reserves the right to underwrite the group as a new group.

Pre-Existing Conditions

A pre-existing condition exclusion is the period of time when care related to that condition would not be covered. Under this plan, the exclusion period will be measured from the date of enrollment and will be a period of (a) 12 months for individuals who enroll timely when first eligible, or due to a HIPAA qualifying event; or (b) 18 months for Late Entrants. The pre-existing condition exclusion will not apply to: (a) newborns or children under the age of 19; or (b) pregnancy. The pre-existing condition exclusion applicable to medical, vision and dental benefits will be reduced by the number of days an individual was covered for these benefits under prior creditable coverage.

Premium Rates and Attachment Factors

Premium rates and attachment factors are guaranteed for the first 12 months. This rate guarantee does not apply to any change in group location or to any change in benefits or coverages.

The following two cost structures are available for premium rates and attachment factors:

Two-tier	Employee
	Employee and Dependent
Four-tier	Employee
	Employee and Spouse
	Employee and Children
	Family

Four-tier is available on any size case. Two-tier is only available on groups with 5 or more dependent units or 3 or more spouses or 3 or more children.

Groups cannot switch between rate structures except at renewal if their enrollment has changed.

On new groups, premium rates and attachment factors will be re-calculated based on final enrollment material.

You may increase the aggregate factors and fixed cost (separately) if you think you can sell more. This will result in higher sales commissions for you.

The minimum annual aggregate deductible must be at least 2 times the group's specific deductible.

The minimum annual aggregate deductible may not reduce by more than 10% as a result of a change in enrollment.

Privacy

As a service provider, it is necessary that we obtain personal – and sometimes sensitive – information about a group and its individuals. Protecting the confidentiality of that information has always been, and will continue to be of utmost concern to American Trust Administrators, Inc. and our affiliates.

ATA is committed to preventing unauthorized access to a group or individual's personal information. As required by law, we will send all of our current clients our most recent privacy notice at least annually.

Professional Employer Organizations

Professional Employer Organizations (PEOs) and Employee Leasing Companies (ELCs) come in many different forms. PEOs may contractually share with the employer the responsibility of hiring, discharging, and directing and controlling the day to day work duties. ELCs may actually become the employer of record for some responsibilities and lease back the employees to the employer, which may still retain full operational control over their employees.

Group's utilizing PEO' or ELCs may be eligible under this plan if they can demonstrate a co-employer relationship. Co-employer here means the agreement between the employer and the PEO/ELC must show that the employer maintains control of hiring, discharging, and directing and controlling the day to day work duties.

In addition to the six items required on a new group (please see Case Submission Process), the following two items are required on groups utilizing such services:

1. The contractual agreement between the employer and the PEO/ELC, and

2. A billing report from the PEO/ELC for the month immediately preceding the requested effective date showing all employees that work for the employer and their wages.

Reinstatements (Groups)

ATA UW may consider reinstating a group that was terminated for one of the following reasons:

- Groups that fall below the minimum number of enrolled employees to maintain the plan

- Groups that do not pay their premium timely (timely means postmarked within the 31 day grace period)

- Groups that don't meet the minimum employee and/or dependent participation level required by the plan

ATA UW will review both the medical and non-medical characteristics of a group in making its decision of whether to allow reinstatement. Groups not reinstated must re-apply as a new group.

Riders

A rider is a legal document that changes the standard plan provisions. All rider requests must be submitted in writing to ATA UW by a corporate officer of the company and are subject to ATA UW approval. ATA Compliance will draft the final rider and a corporate officer of the company must sign-off on the final rider language. Riders that affect premium rates and/or attachment factors will only be permitted at issue and/or renewal.

Sales Proposal

ATA UW will re-run all sales proposals reflecting final enrollment and underwriting materials. The ATA rating system accepts both the group's home office zip code and each employee's resident zip code; **final proposed rates will be calculated using the zip code provided on each Employee Enrollment/Refusal Form.**

Final rates may be higher than quoted rates due to a group's individual health conditions, participation, turnover, no prior medical coverage, changes in census or benefits and changes in effective date.

State Continuation

Persons on state continuation from a prior plan are not eligible under this plan.

Telephone Medical Interviews

Please inform your client that ATA UW will conduct telephone medical interviews with eligible employees and their dependents to obtain additional medical information in lieu of obtaining medical records. However, ATA UW will evaluate medical records if obtained at your expense.

Interviews will be conducted on anyone electing medical coverage that answers "Yes" to any health statement question that the Underwriter needs more details on to fully evaluate the risk.

In most cases, the interview will replace the need to obtain attending physician statements and medical records. Attending physician statements and medical records may still be ordered, however, for a more comprehensive review of severe and/or multiple disorders.

Twenty Four Hour Coverage

Medical coverage may be provided for on-the-job injuries to c*orporate officers,* p*artners or sole proprietors* who are not covered by Worker's Compensation insurance. The person must be an employee or officer of the group. This coverage only provides medical benefits for such persons and does not provide disability or

employer liability benefits. **The name, date of birth, occupation, and a detailed description of the daily duties must be provided to ATA UW during the underwriting process**.

This coverage is elected at the employee level on the census screen in the ATA Rating System. Premium rates and attachment factors will be loaded 15% on such individuals approved for this coverage and this cost will be spread over the cost for all eligible employees. ATA UW reserves the right to refuse such coverage to any individual engaged in an occupation ATA UW deems hazardous or dangerous. Individual state regulation may prohibit employers from opting out of Worker's Compensation coverage.

Waiting Period

A waiting period is the time that an eligible employee must be continuously actively working full-time for the employer or the time a person must remain an eligible dependent before coverage begins. There are two types of waiting periods on a group, present and future. The present waiting period applies to timely employees hired on or prior to the effective date of the plan. The future waiting period applies to timely employees hired after the effective date of the plan. Present and future employees may have different waiting periods. Waiting periods can range from 0 to 12 months by increments of one month and cannot include days.

Coverage may begin on the first of the month following the satisfaction of the waiting period or on the first day following the satisfaction of the waiting period. All present employees and their dependents must have the same waiting period and all future employees and their dependents must have the same waiting period, i.e. the coverage begin option must be the same for present and future employees. Generally, eligible dependents are eligible for coverage after the employee satisfies his/her waiting period.

Waiting periods by class of employee (please see Classes of Employees) are discriminatory on medical benefits and, as a result, are not allowed. Waiting periods by class of employee are permitted on fully insured life and AD&D coverage.

Please consider the following examples of waiting periods.

1st of the Month Following

5/1 Date of Full Time Employment
3 Month Group Waiting Period
Eligible for Coverage on 8/1

5/15 Date of Full Time Employment
3 Month Group Waiting Period
Eligible for Coverage on 9/1

Immediately Following

5/15 Date of Full Time Employment
3 Month Group Waiting Period
Eligible for Coverage on 8/16

Year-Round Coverage

Employees who are considered full-time but may work less than a continuous full twelve month calendar year period (for example seasonal and/or employees subject to temporary layoffs) may sustain lapses in coverage. Individual consideration to cover these individuals year-round may be given by ATA UW on a case-by-case basis. A rider to the plan may be required.

American Trust Administrators, Inc.
Agent Appointment and Solicitation Rules

ALL AGENTS MUST HOLD A VALID LICENSE IN THEIR HOME STATE AND IN ANY OTHER STATE WHERE THEY SOLICIT BUSINESS.

STATE	WILL THE INSURANCE COMPANY APPOINT THE AGENT, THE AGENCY OR BOTH?	WHEN CAN THE AGENT SOLICIT?	WHEN CAN THE AGENT RECEIVE COMMISSIONS?
Alabama	Agent Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Arizona	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Agent may solicit immediately.	Immediately
Arkansas	BOTH	Agent does not need an appt. in hand with first piece of business, but should obtain one within **15** days.	After approval is received from the state.
California	Agency/If the agent is affiliated, check CA website, only appoint the agency.	Agent does not need an appt. in hand with first piece of business, but should obtain one within **14** days.	After Appt. submitted to State
Colorado	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Agent may solicit immediately.	Immediately
Connecticut	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After Appt. submitted to State
Delaware	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
District of Columbia	BOTH	Agent does not need an appt. in hand with first piece of business, but must be appointed within **30** days.	After approval is received from the state.
Florida	Agents Only	Appointment required prior to solicitation with FSL or another carrier.	After approval is received from the state.
Georgia	Agents Only	Appointment required prior to solicitation.	After appointment is submitted to the state.
Idaho	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After appointment is submitted to the state.

American Trust Administrators, Inc.
Agent Appointment and Solicitation Rules

STATE	WILL THE INSURANCE COMPANY APPOINT THE AGENT, THE AGENCY OR BOTH?	WHEN CAN THE AGENT SOLICIT?	WHEN CAN THE AGENT RECEIVE COMMISSIONS?
Illinois	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Immediately	Immediately
Indiana	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Immediately.	Immediately
Iowa	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **30** days.	After approval is received from the state.
Kansas	BOTH, must appoint all agents within agency	Agent does not need an appt. in hand with first piece of business but must secure one within **30** days.	After approval is received from the state.
Kentucky	Agent or Agency	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Louisiana	BOTH	After approval is received from the state.	After approval is received from the state.
Maine	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Maryland	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Immediately	Immediately
Massachusetts	BOTH, Agency must include appointment for all producers	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Michigan	BOTH	Agent does not need an appt. in hand with first piece of business, but must be submitted within **15** days.	After approval is received from the state.
Minnesota	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Mississippi	Agents Only	Agent does not need an appt. in hand with first piece of business, but must be submitted within **15** days.	After approval is received from the state.

American Trust Administrators, Inc.
Agent Appointment and Solicitation Rules

STATE	WILL THE INSURANCE COMPANY APPOINT THE AGENT, THE AGENCY OR BOTH?	WHEN CAN THE AGENT SOLICIT?	WHEN CAN THE AGENT RECEIVE COMMISSIONS?
Missouri	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Agent may solicit immediately.	Immediately
Montana	Agent or Agency	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	Immediately after appointment sent to state.
Nebraska	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Nevada	Agency if the agency is receiving commission. Agency Appointment covers all licensed producers in the agency.	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
New Hampshire	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
New Jersey	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
New Mexico	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	Immediately after appointment sent to state.
North Carolina	Agents Only	5 Working days after appt. submitted to state	After approval is received from the state.
North Dakota	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Ohio	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **30** days.	After approval is received from the state.
Oklahoma	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Oregon	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Immediately.	Immediately

American Trust Administrators, Inc.
Agent Appointment and Solicitation Rules

STATE	WILL THE INSURANCE COMPANY APPOINT THE AGENT, THE AGENCY OR BOTH?	WHEN CAN THE AGENT SOLICIT?	WHEN CAN THE AGENT RECEIVE COMMISSIONS?
Pennsylvania	BOTH	Agent may solicit after appointment is submitted to the state.	Agent may receive commissions after appt. submitted to the state.
Rhode Island	Appointment with state not required. Send Affiliation notice to FSL for who ATA will pay commissions.	Immediately.	Immediately
South Carolina	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
South Dakota	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Tennessee	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Texas	BOTH	Agent may solicit after appointment is received.	After approval is received from the state.
Utah	BOTH	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Vermont	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Virginia	Agent or Agency. Agency must include affiliated agent	Agent does not need an appt. in hand with first piece of business, but must be appointed within **30** days.	After approval is received from the state.
Washington	Agent or Agency	After approval is received from the state.	After approval is received from the state.
West Virginia	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Wisconsin	Agents Only	Agent does not need an appt. in hand with first piece of business but must secure one within **15** days.	After approval is received from the state.
Wyoming	Agents Only	Agent does not need an appt. in hand with first piece of business, but should obtain one within **15** days.	After approval is received from the state.