PLAN SPONSOR (EMPLOYER) STATEMENT

INSTRUCTIONS FOR COMPLETION

"Plan Sponsor" refers to the employer; "Plan" refers to the employer's health plan for its employees; "Plan Benefits" refers to the self-funded benefits selected by the employer (in Section 3). If the Plan Sponsor permits independent contractors to participate in its Plan, references to “employee” and “employment” include independent contractors and their relationship with the Plan Sponsor. Use of such terms is solely for convenience and does not establish an employment relationship nor alter or waive the independent contractor status.

Section 1 – Provide Plan Sponsor contact information

Section 2 – Provide all requested information for Plan Sponsor and its Plan

Section 3 – Select the Plan Benefits

Section 4 – Plan Sponsor must read and sign

Section 5 – Agent of Record Information – complete & sign

Case submission checklist - The following required items must be enclosed:

- ❑ **A business check for the estimated total cost of the Plan Benefits for the first month made payable to: Allied National, Inc.**
- ❑ **This completed Plan Sponsor Statement (all items must be fully completed).**
- ❑ **Fully completed enrollment form or waiver on every eligible employee.**
- ❑ **Copy of Plan Sponsor's most recent state quarterly unemployment tax report.**
- ❑ **Copy of proposal showing selected Plan Benefits and total monthly cost.**
- ❑ **Copy of Plan Sponsor's most recent billing (for its current health plan coverage).**
- ❑ **Copy of Plan Sponsor's renewal notice (for its current health plan coverage).**

SECTION 1 – PLAN SPONSOR CONTACT INFORMATION

Company Name _____

Primary Contact _____ Tax ID # _____

Physical Address _____

Mailing Address (if different) _____

City _____ County _____ State _____ Zip _____

Main Phone # _____ Contact’s Phone # _____

Contact Email Address _____

SECTION 2 – PLAN & PLAN SPONSOR INFORMATION

1. Plan Sponsor is a: ❑ Sole Proprietorship ❑ Partnership or L.L.C. ❑ Corporation ❑ Other: _____

2. Specific nature of Plan Sponsor's business: _____ SIC Code: _____

3. Does Plan Sponsor have an affiliate, subsidiary or parent company? .....❑ Yes ❑ No If "Yes", provide name, address and percent of common ownership: _____

   Do employees of the affiliate, subsidiary or parent company participate in Plan Sponsor's health plan?..... ❑ Yes ❑ No

4. Name of person at Plan Sponsor handling health plan details: _____

5. Does Plan Sponsor currently have health plan coverage in-force (or within the past 90 days)? ..... ❑ Yes . ❑ No
   If "Yes", please provide the: 1) start date of coverage _____
   2) end date of coverage (if applicable) _____ and
   3) # of former employees currently on COBRA (or state) continuation coverage _____

6. Does Plan Sponsor classify full time employment as working at least 30 hours per week? .... ❑ Yes ❑ No
   Will only full-time employees be eligible to participate in Plan Sponsor's health plan? ..... ❑ Yes ❑ No
   (If "No" to either or both, please provide details on another sheet. Approval is subject to additional review.)

7. Please certify the following ("full-time" is working at least 30 hours per week):
   A. Plan Sponsor currently employs _____ **full-time** employees [including owner(s), partners, and officers].
   B. Including **all types** of employees (full-time, part-time, temporary, seasonal and union), Plan Sponsor employed _____ employees on an average business day in the preceding calendar year.
   C. Plan Sponsor was established (or first conducted business) on (month & year) _____
   D. Plan Sponsor's health plan currently has_____ former employees on COBRA or state continuation or coverage.
   E. Within the past 90 days, _____ **full-time** employees terminated employment with Plan Sponsor (voluntarily or not).

8. Does Plan Sponsor's health plan exclude any class of employee from eligibility? ..... ❑ Yes ❑ No
   If "Yes", please describe the class(es) (any class exclusion must be non-discriminatory and approved in advance):

   _____

9. Plan Sponsor consents to periodic reviews of its employment records, for purposes of verifying the number and names of all employees eligible to participate in Plan Sponsor's health plan, and agrees to furnish, upon request, a current employee census and state unemployment tax report. .....❑ Yes ❑ No

10. Plan Sponsor selects the following waiting periods for its health plan:
    A. If hired on/before the effective date of the Plan being established, an employee becomes eligible upon completion of: ❑ 0 months ❑ 1 month ❑ 2 months
    B. If hired after said effective date, an employee becomes eligible on the first day of the month coinciding with or next following the completion of: ❑ 1 month ❑ 2 months

    A fully completed enrollment form must be received by Allied National prior to the employee effective date.

11. Will any HRA or GAP plan, insured or self-funded, be used to supplement this self-funded Plan? ……..❑ Yes ❑ No
    (If Yes, please describe or provide a copy of the HRA/GAP benefit schedule):

    _____

12. For the Plan Benefits selected below, Plan Sponsor requests an effective date of _____. Plan Sponsor acknowledges that approval of the Stop-Loss Insurance is dependent upon all required paperwork being fully and properly completed, signed on or before the requested effective date, submitted to Allied National within five (5) business days thereafter, and then approved in writing.

13. To defray the costs of employee coverage under Plan Sponsor's health plan, Plan Sponsor agrees to contribute: _____% or $_____ to Employee Coverage (must be at least 25%); and _____%, or $_____to Dependent Coverage (optional - dependent contributions are not required).

14. Plan Sponsor acknowledges and understands that the following minimum participation requirements will apply to the Plan Benefits selected below: At least 75% of eligible employees must participate. Failure to maintain this requirement for three (3) consecutive months will result in termination of the Plan Benefits, **including the Stop-Loss Insurance**. If that occurs, Plan Sponsor will be liable for 100% of the cost of all claim payments under its Plan.

15. Plan Sponsor further acknowledges and understands that: Stop-Loss Insurance is an annual insurance contract and not guaranteed renewable; access to all available benefits under the Stop-Loss Insurance is subject to the Stop-Loss Insurance policy remaining in effect for the entire policy year and meeting the minimum specific and annual aggregate deductibles (as described in the Stop-Loss Insurance policy); and early termination of said Stop-Loss Insurance may result in reduction of benefits and/or increased claim exposure.

SECTION 3: BENEFITS SELECTION

ADMINISTRATOR'S USE ONLY
CASE # _____
POLICY # _____
EFFECTIVE DATE _____

Indicate which Plan Benefits you are selecting:

- ❑ Premium Advantage PPO Plan
  Indicate PPO Network Selection: _____
- ❑ HSA Qualified Plan
  Indicate PPO Network Selection: _____
- ❑ MediPay ❑ PMEC ❑ MEC Value
- ❑ HSA MediPay ❑ HSA Provider Freedom ❑ MVP 50 Plus
- ❑ Provider Freedom (no PPO network, use any provider)

❑ Check here if multiple benefit plans are being used in a dual choice offering.

Attach a copy of the proposal to document the selected benefits. Eligibility, product availability and monthly costs are subject to underwriting.

SECTION 4 – CERTIFICATION & SIGNATURE

Plan Sponsor, by its authorized representative named below, acknowledges, agrees, accepts and/or consents to the following:

The Plan Benefits selected above represent a program of services designed for Plan Sponsor's health plan ("Plan") and includes the provision of a summary plan description for the Plan ("Plan SPD"), administrative services ("Delegated Services") and Stop-Loss insurance coverage ("Stop-Loss Insurance"). Plan Sponsor consulted with the agent of record and reviewed the Plan Benefits brochure and guide before making its selection. The specific benefits selected by Plan Sponsor for its health plan are stated in the signed proposal attached to the Stop-Loss Insurance application.

Plan Sponsor's health plan is a self-funded Employee Welfare Benefit Plan established for its employees. Certain rights granted by the "Employee Retirement Income Security Act of 1974" (ERISA), the "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA), the "Health Insurance Portability and Accountability Act of 1996" (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA), and other federal and state benefit laws apply to the participating employees. Plan Sponsor retains all plan sponsor, plan administrator and plan fiduciary responsibilities under said benefit laws. Plan Sponsor remains responsible for compliance with said benefit laws, including all mandatory notices to participants and all regulatory reports and filings. HIPAA guaranteed availability and renewability do not apply to the self-funded Plan Benefits or the Stop-Loss Insurance.

No liability is created or assumed by the insurance company under the Stop-Loss Insurance until the Stop-Loss Insurance application has been approved in writing. If for any reason the application is not approved, the sole obligation of the insurance company will be, and Plan Sponsor shall be entitled to only, a refund of any premiums paid. A claim incurred by a Plan Sponsor employee is eligible for benefits under the Stop-Loss Insurance only if that employee was covered under the Plan at the time the claim was incurred. Coverage under the Stop-Loss Insurance is based on the Plan SPD. Any change to the Plan SPD, or any benefit payment inconsistent with the Plan SPD, may not be covered under the Stop-Loss Insurance. Plan Sponsor shall reimburse the Stop-Loss Insurance for any ineligible benefits, including expenses incurred under the Plan's Outpatient Prescription Drug Card Benefit, and any advances issued pursuant to the accommodation provision in the Stop-Loss Insurance.

Plan Sponsor has engaged the agent of record shown below as its Plan consultant, to assist in establishing and/or maintaining the Plan and in securing the Plan Benefits (including the Plan SPD and Stop-Loss Insurance) and the Delegated Services. The agent of record will receive a portion of the fees charged for the Plan Benefits as compensation for those consulting services. The agent of record has no authority to bind the Stop-Loss Insurance or alter its terms.

Plan Sponsor has also engaged Allied National to act as the third party administrator for the Plan, which includes the delegation to Allied National of certain non-fiduciary, ministerial administrative acts, duties or responsibilities on behalf of the Plan. The Delegated Services have been negotiated via a separate administrative services agreement, between the Plan Sponsor and Allied National, and are not part of the Stop-Loss Insurance. None of the premium charged for the Stop-Loss Insurance will pay for (or be allocated to) the Delegated Services, and none of the fees charged for the Delegated Services will pay for (or be allocated to) the Stop-Loss Insurance. If the Stop-Loss Insurance is not approved, Allied National will have no obligation to provide the Delegated Services to Plan Sponsor. Delegated Services include, but are not limited to:

- Tracking employee and dependent enrollment in the Plan;
- Billing, collecting, holding and disbursing Plan funds, from which to pay claims and Stop-Loss Insurance premiums;
- Providing utilization review services for inpatient admissions, maternities and certain outpatient services;
- Processing provider claims to determine and pay Plan benefits, as provided under the terms of the Plan;
- Billing, collecting and remitting agent of record consulting fees; and
- Arranging access to, and billing and remitting fees for, discounted fee arrangements (including managed care and pharmacy networks) and wellness programs (or similar employee support programs).

Employer and employee Plan contributions provided by Plan Sponsor (to pay benefits and expenses under the Plan) will be held in trust by the Stop-Loss Insurance company, with similar funds provided by sponsoring employers of other plans, in an interest bearing bank account administered by Allied National. All earned and accrued interest shall be retained by Allied National (as part of its reasonable compensation for the Delegated Services). If eligible benefit payments exceed Plan contributions, funds may be advanced to the employer by the Stop-Loss Insurance company (under the Stop-Loss Insurance accommodation provision). If eligible benefit payments exceed the agreed to specific or aggregate maximums, coverage becomes available under the Stop-Loss Insurance.

I have authority to represent and act on behalf of Plan Sponsor in submitting this Plan Sponsor Statement, the answers and information provided in this Plan Sponsor Statement are complete and true to the best of my knowledge and belief, and I understand that any material misrepresentation or omission in this Plan Sponsor Statement may nullify coverage under the Stop-Loss Insurance coverage.

Signed at _____ (City & State)

Signature _____

Name (Print) _____

Date _____

Title _____ (Must be signed by Firm Owner, Partner or Officer)

Final monthly costs and eligibility are determined at the time of underwriting. DO NOT cancel current coverage until written notice of approval of Stop-Loss coverage has been received from Allied National.

SECTION 5 – AGENT OF RECORD INFORMATION

Producer's Name _____ Allied Agent # _____

Agency or Company _____

Address _____

City _____ State _____ Zip _____

Telephone ( ) _____ Fax ( ) _____

Social Security Number or TIN _____ Email Address _____

Pay consulting fees to: ❑ Agent _____ ❑ Agency _____

DELIVERY OF PLAN MATERIALS

Plan materials, including ID Cards, are routinely sent to you for delivery to your client.

❑ Check here if you wish for Plan materials to be sent directly to your client.

PRODUCER'S STATEMENT

I am now appointed with the Stop-Loss carrier in the state where this employer is located. ❑ Yes ❑ No

I hereby certify that all of the information contained in this Plan Sponsor Statement and in the employee enrollment forms is correct to the best of my knowledge, and I know of no adverse information concerning this employer or any individual's health status other than as disclosed. I have complied with the underwriting rules and regulations and have explained in detail the self-funded plan and Stop-Loss coverage to the employer.

I hereby acknowledge the consulting fees paid to me by the employer will be billed and collected on my behalf by Allied National and that those fees are based on the actual enrollment in any month.

Date Completed _____ Signature of Agent _____

Distributor name and number: _____

RETURN TO: UNDERWRITING • ALLIED NATIONAL • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187

Electronic copies of this form submitted via facsimile, email or other electronic means shall be deemed an original.