MID-AMERICA
FULLY FUNDED HEALTH PLANS
Employer Application

by MID-AMERICA
EMPLOYEE BENEFIT ADMINISTRATION

Patient Protection &
Affordable Care Act
Employer Health Plan
Options
for Businesses with
up to 50 Employees

FULLY FUNDED EMPLOYER APPLICATION

EMPLOYER GROUP INFORMATION

The Employer Plan Name		Requested Coverage Date:	Deductible Accumulates on: ☐ Calendar Year ☐ Plan Year
FIRM NAME (legal name)		Tax ID#	
Address	City	State	Zip Code

NOTE: If multiple locations are to be identified separately, please list here:

Name/Address	City	State	Zip Code

Employer Contact Name	Contact Title	Contact Phone	Contact Fax

Contact Email Address

Business is a ☐ LLC ☐ Partnership ☐ Corporation	Nature of Business	Total Number of Employees - including employees NOT enrolled for Coverage Full Time_____ Part Time_____ Seasonal_____

New employees are covered on the first of the month following:
☐ 30 days ☐ 60 days ☐ 90 days Coverage begins on 91st day.

Coverage Reinstatement Provision: __ None 1st of month following: 30 days ___60 days _____other (not to exceed 6 months) from date of temporary lay-off.

Indicate the percentage of employees costs which the employer will pay for employees_____% and dependents_____%	Name of Worker's Compensation Carrier (answer #6 below)
Has the employer had Group Medical Coverage for the past 12 months? ☐ Yes ☐ No If yes, attach a copy of the most recent billing statement. Employer is: ☐ Single employer, under 50 total employees. Employer files 1094-B Transmittal of Health Coverage Information Return.	Carrier Name, Address and Phone Number

☐ A Large Employer over 50 employees and/or employer under common ownership with over 50 combined employees. Employer files 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Return.

EMPLOYER GROUP PLAN INFORMATION

1. What is the renewal date of your current group health plan?:_____

2. Is coverage actively in force? ☐ Yes ☐ No If no, provide date and reason for coverage lapse:_____

3. Are any employees or dependents applying for coverage currently disabled, hospital confined, or not working full-time at least 30 hours per week?
   ☐ Yes ☐ No If yes, attach written details.

4. Is any employee currently on temporary lay-off, disability, leave of absence or family medical leave?
   ☐ Yes ☐ No If yes, attach written details.

5. Is any person currently receiving or eligible for continuation of benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)?
   ☐ Yes ☐ No If yes, attach written details and a copy of each COBRA election form including the name of the current COBRA administrator.

6. Are all employees applying for coverage currently covered under Worker's Compensation?
   ☐ Yes ☐ No Provide names of applicants not covered under Worker's Compensation.

7. For Employers with fewer than 20 total employees, Medicare is primary payer. Active employees or spouses eligible for Medicare must be enrolled for Medicare Parts A & B. Are any applicants now applying for coverage eligible for Medicare?
   ☐ Yes ☐ No If yes, provide copy of Medicare ID card. If applicant is Medicare eligible and not enrolled in Parts A & B, benefits are reduced. Employer agrees to notify affected applicants that Medicare enrollment is required upon effective date of group coverage.

8. Are all eligible full-time employees offered coverage under this plan? ☐ Yes ☐ No If no, are employees provided coverage under another Plan? ☐ Yes ☐ No If yes, how many employees are covered under another health plan sponsored by Employer?_____
   Explain reason for maintaining 2 or more separate group health plans:_____
   If more than one group health plan, do employee's have option to elect this plan at Open Enrollment? ☐ Yes ☐ No

9. Open Enrollment allows for a coverage effective date on the Plan Anniversary Date when enrolled timely. Does Employer require an alternate Open Enrollment Period? ☐ Yes ☐ No
   If yes, define Employer's Open Enrollment Period:_____

MID AMERICA
EMPLOYEE BENEFIT ADMINISTRATION

EMPLOYER PLAN COVERAGE REQUESTED

Standard Base Plan Deductible (2x Family)
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $7,000
Out-of network = 2 times deductible elected

Co-Insurance (Out-of-Network in Parenthesis)
☐100% (50%) ☐90% (50%) ☐80% (50%)

Stop Loss (2x Family)
☐ $5,000 ☐ NONE*

Doctors Office Visit Co-Pay
☐ $10 ☐ $30

Prescription Drug Card Benefit
☐ $15/$30/$50/20% ☐ $20/$40/$80/20%
☐ $30/$60/$120/20%

Optional Pediatric Dental
(Subject to Medical Plan Deductible and Co-Insurance)
☐ Yes ☐ No

HEALTH SAVINGS ACCOUNTS (HSA'S)
PLAN DESIGN OPTIONS

Health Savings Account (HSA) Deductible:

Non-Embedded	Embedded
Self Only / Family	Per Person / Family
☐ $2,000/$4,000	☐ $4,000/$8,000
☐ $3,000/$6,000	☐ $5,000/$10,000
	☐ $7,000/$14,000

HSA Co-Insurance (Out-of-Network in Parenthesis)
☐ 100% (50%) ☐ 80% (50%)

Select Deductible/Co-insurance Accumulation Type:
____ Calendar Year ____ Plan Year

HSA Stop Loss (2x Family)
☐ $5,000 ☐ None *

*None = Annual HSA maximum out of pocket limit (deductible plus coinsurance).

Optional Pediatric Dental
(Subject to Medical Plan Deductible and Co-Insurance)
☐ Yes ☐ No

Dental Yes _____ No _____ Plan Requested _____

Ortho Rider Yes _____ No _____

SUMMARY OF MONTHLY COSTS

Attach plans most recent quote. Final administrative fees, premiums and the level monthly claim fund costs will be based upon the data of employees and dependents actually enrolled.

PLAN IMPLEMENTATION CHECKLIST

PLEASE VERIFY EACH ITEM BELOW and make certain all items are included with plan submission.

- ☐ COMPLETED EMPLOYER PLAN APPLICATION AND SIGNED AGREEMENT.
- ☐ PRODUCER'S CONTRACT & COPY OF LICENSE (with first group submission.)
- ☐ COMPLETED EMPLOYEE APPLICATIONS (Including those in their waiting period, on COBRA Continuation, or in COBRA election period and those electing Life/AD&D only.) Late applications submitted after group effective date will not be accepted.
- ☐ FOR THOSE WAIVING COVERAGE, APPLICATION FORMS WITH WAIVER SECTION COMPLETED AND SIGNED.
- ☐ MOST RECENT PRIOR CARRIER BILLING WITH EFFECTIVE DATE OF EACH ENROLLEE. (Please verify that there is an enrollment or a waiver for each individual listed on the prior carrier bill.)
- ☐ MOST RECENT QUARTERLY WAGE/TAX REPORT.
- ☐ EMPLOYER CENSUS DECLARATION.
- ☐ ORIGINAL GROUP QUOTE RECEIVED FROM MID-AMERICA ASSOCIATES, INC.
- ☐ FIRST MONTH'S ADMINISTRATIVE FEES, PREMIUMS AND THE LEVEL MONTHLY CLAIM FUND COSTS PAYABLE TO MID-AMERICA ASSOCIATES, INC.
- ☐ PROOF OF WORKER'S COMPENSATION COVERAGE
- ☐ SIGNED DOCUMENTS TO INCLUDE: EMPLOYER APPLICATION, PLAN DOCUMENT, ADMINISTRATIVE SERVICES AGREEMENT, EXCESS LOSS APPLICATION, DISCLOSURE FORM AND COMPLETED COBRA ADMINISTRATION ELECTION FORM.

Employee applications must be filled out completely, each question must be answered for EACH APPLICANT (SPOUSE AND CHILDREN). Details must be provided for ALL "YES" answers including details on medications, dates of service, physicians name, address, etc. Signature of both employee, spouse and dependent children 18 years and older must be included. Neither the Employer or Agent is authorized to complete or sign Enrollment Applications on behalf of applicants.

Fully Funded Employer Application

1. It is understood that no coverage is in effect until administrative fees, premiums and the level monthly claim fund costs have been received and notice of approval has been given by Mid-America Associates, Inc.

2. The undersigned Employer acknowledges and agrees that no one other than Mid-America Associates, Inc. or a person designated in writing by Mid-America Associates, Inc. may accept this application on behalf of Mid-America Associates, Inc. The undersigned employer agrees to comply with any applicable state laws, federal statutes or regulations regarding its operation.

3. The undersigned Employer acknowledges that only eligible full-time active employees working a minimum of 30 hours per week on average and included on regular payroll are eligible for coverage.

4. Administrative fees, premiums and the level monthly claims fund costs are payable monthly and due on the first of each month. The undersigned Employer understands and agrees to pay all monthly administrative fees, premiums and level monthly claims fund costs as of the effective date of coverage through the Plan Anniversary Date. Non-payment of administrative fees, premiums and level monthly claim fund costs does not discharge the undersigned from this obligation. The undersigned Employer understands that changes to coverage may be made on the Plan Anniversary Date only. The undersigned Employer also understands that rates may be modified at each Anniversary Date, or sooner if there is a significant change in participation and/or non-disclosure or intentional misrepresentation during the enrollment process by the Employer or Member.

5. The undersigned Employer understands the underwriting and participation requirements. In the event participation fails to meet minimum standards, or should the applicant submit false or incorrect information, the risk to premium ratio will be re-examined or coverage will be rescinded. Benefit coverage will become effective on the first of the month as requested and approved by Underwriting. Mid-America Associates, Inc. reserves the right to rate coverage for the appropriate medical risk or decline coverage if all enrollment, participation or contribution requirements are not met.

6. The undersigned Employer understands that if administrative fees, premiums and level monthly claims fund costs are not received by the due date (first of each month), payments for claims incurred on or after the due date shall be discontinued until administrative fees, premiums and level monthly claims fund costs are paid in full. If administrative fees, premiums and level monthly claims fund costs are not received within 31 days after the due date, the Employer's coverage will terminate and no claims incurred on or after the premium due date will be paid. The Employer will be responsible for payment of prescription drug card benefits used during the Grace Period and applicable funding of claims incurred prior to coverage termination.

7. The undersigned Employer understands and agrees that Mid-America Associates (Third Party Administrator) does not assume the Employers responsibilities for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

8. The undersigned Employer acknowledges that concurrent with participation in the Plan, Pre-Certification and Prior-Authorization is required for specific services under the Plan. The applicant agrees to participate and comply with the Pre-Certification and Prior-Authorizations Programs. Failure by any Member to obtain Pre-Certification and/or Prior-Authorization will result in a reduction or denial of benefits. The applicant understands that compliance with the provisions of the Pre-Certification and/or Prior-Authorization Programs does not constitute a confirmation of eligibility or assure the services billed are payable or eligible expenses. All terms, limitations and exclusions contained in the Plan will apply.

9. Deposit of one (1) month's administrative fees, premiums and level monthly claim fund costs in the amount of $_____, made payable to Mid-America Associates, Inc. is enclosed with this application. It is understood that if this application is not approved, said deposit will be refunded. Do not cancel current coverage until after notice of approval has been received from Mid-America Associates, Inc.

Applicant's Statement

I hereby verify that the preceding information is complete and accurate. Employee applications have been completed, signed and dated by the individual applying for coverage. Any alterations to these applications that may have been made are initialed by the individual applying for coverage. I confirm that all eligible employees including those not actively at work will have completed either an application or waiver of coverage. I understand late applications received after the Plan effective date will not be accepted. I also understand the underwriting of individual applications has been predicated upon the answers to questions contained herein. Material misrepresentation of facts including intentional non-disclosure on the part of the Employer, Employee or dependent will result in rescission of coverage or retroactive adjustments to the administrative fees, premiums and level claims fund costs.

Applicant's Signature Month Day Year

Agent's Statement

I hereby confirm that applications have been completed, signed and dated by the individual applying for coverage. Any alterations to these applications that may have been made are initialed by the individual applying for coverage. I understand that the underwriting of the individual applications taken in this case were predicated upon the answers to the questions in said applications and where there has been a material misrepresentation of facts including intentional non-disclosure on the part of the Employer, Employee or Dependent, rescission of coverage or retroactive adjustments to administrative fees, premiums and level claim fund costs will occur. As the undersigned Agent, I have reviewed the Employer and Employee Applications and have no knowledge of material misrepresentation or non-disclosure of fact. I have reviewed the requested coverage for accuracy and it complies with the coverage the employer desires.

Writing Agent's Signature Month Day Year

General Agent's Signature Month Day Year

Administered by:

Mid America Associates, Inc.

560 Kirts Blvd., Suite 125
Troy, MI 48084
(800) 482-0945

Fraud Warning:

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of fraud.

LIBERTY UNION LIFE ASSURANCE COMPANY

APPLICATION FOR:
Excess Loss Insurance Coverage

Proposed Coverage For:

1. **Name of Employer** (Full Legal Name Required):_____

_____

2. **Name of Proposed Plan Sponsor** (if different from Employer):_____

_____

3. **Address:**_____
(Street)

_____
(City) (State) (Zip Code)

_____ _____
(Contact Phone) **(Contact Email)**

4. **Subsidiaries or Affiliated Companies** (companies under common control through stock ownership, Contract or otherwise) to be included (List legal name and addresses. Attach an additional page if more space is needed.):

_____

_____

PROVIDE ALL OF THE FOLLOWING:

5. Nature of Business or SIC Code:_____
6. Total Number of Employees Eligible for Coverage:_____
7. Total Number of Employees Enrolling Under This Plan:_____
8. Total Number of Part-Time Employees (employed but not eligible for coverage):_____
9. If 100% of eligible employees are not enrolling under this Plan, provide proof of other group health coverage sponsored by employer. If no coverage, provide explanation:_____

_____

10. Provide copy of current proof of group health coverage (premium bill, TPA consolidated bill) showing names and effective dates of eligible employees enrolling for coverage.
11. Provide copy of current plan document or insurance certificate of coverage.
12. Claims experience with enrollment by month for last 24 month period. If not available, please explain:

___Not available, current coverage is fully-insured and under 100 lives.

___Other: _____

LIBERTY UNION LIFE ASSURANCE COMPANY

APPLICATION FOR:
Excess Loss Insurance Coverage

1. SELECT GENERAL OPTIONS:

(a) **Proposed Contract Period: from:_____ through:_____**
"Proposed Contract Period" is the requested effective date of coverage ("from") ending on the last day of the 12th calendar month ("through").

(b) *Disabled Persons ___are covered ___are not covered
Retired Employees ___are covered X__are not covered
***Persons must be listed under a separate document for (b) if "are covered" is elected.**

Aggregate Contract Basis

Plan Document expenses must be:

Incurred from:_____ through:_____
"Aggregate Incurred Period" is the effective date of the plan year ("incurred from") ending on ("through") the last day of the 12th calendar month, and

Paid from _____ through:_____
"Aggregate Paid Period" is the 24 months beginning on plan year effective date ("paid from") and ending 24 months ("through") following the plan year effective date.

Claims incurred prior to the Contract Effective Date are limited to: $ 0.00

Aggregate Eligible Expenses include the following coverage:

___Medical ___ Prescription Card Service ___Dental

(c) **Monthly Aggregate Accommodation Benefit:** Included
"Monthly Aggregate Accommodation" means excess loss coverage is automatically advanced for payment of claims exceeding the monthly or annual aggregate attachment point.

2. EMPLOYER/PLAN SPONSER ACKNOWLEDGEMENT
The undersigned acknowledges that this Application is not binding until it is accepted by the Insurer. The proposed Plan Sponsor agrees to provide confirmation that no lapse in coverage from the current carrier or Plan occurs and acknowledges that the "Proposed Contract Period" is subject to change.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

_____ _____
Signature of Authorized Plan Sponsor (Authorized Employer Representative) Date

_____
Printed Name and Title

3. Name of Agent:_____ **Agency Name**:_____

Phone:_____ **Email:**_____

_____ _____
Signature of Agent Date

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement and accompanying exhibits and appendices which are attached hereto and incorporated herein (collectively referred to as the "Agreement") is made and entered into this _____ day of _____ , 20_____ (the "Effective Date"), by and between _____, a [corporation] duly organized and existing under the laws of the State of _____ with its principal place of business at _____ _____ (hereinafter referred to as the "Plan Sponsor") and Mid-America Associates, Inc corporation duly organized and existing under the laws of the State of Michigan with its principle place of business at Troy, Michigan (hereinafter referred to as the "Administrator".

10.18 Authority. Each party represents and warrants to the other that the signatory identified beneath its name below has authority to execute this Agreement on its behalf. The parties, intending to be legally bound, have executed and delivered this Agreement as of the date set forth.

IN WITNESS WHEREOF, the parties confirm delivery and acceptance of this Agreement by the Plan; the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective the _____ day of _____, 20_____

- *The parties acknowledge the signatures represented on the Summary Signature Pages, will for all purposes, be considered as full execution and acceptance of this "Agreement" in its entirety.*

ADMINISTRATOR: Mid-America Associates, Inc.

_____

Authorized Signature of Administrator Date

_____

Printed Name of Authorized Administrator Title

_____

Date Plan Approved

PLAN SPONSOR

_____

Signature of Authorized Plan Sponsor (Employer) Date

_____

Printed Name Title

APPENDIX A – DISCLOSURE FORM

Agent (Full Name):_____

Administrator: Mid-America Associates, Inc.

In conjunction with the sale of the group health plan you have selected to purchase, this arrangement does not limit your Agent and/or Administrator from marketing for other insurance companies or organizations.

The Agent and/or Administrator may be entitled to commissions and/or marketing allowances on such contracts, expressed as a percentage of gross annual premium and/or a flat dollar amount, as follows:

AGENT	**ADMINISTRATOR**
_____ % of Aggregate Premium	_____% of the Aggregate Premium
_____ % of Administration Fee	_____% of Administration Fee
_____ Other	25% Subrogation Recoveries
	Full PBM Rebates

In addition to commissions, Agent and/or Administrator may receive additional compensation in the form of cash bonus and/or certain travel bonuses awarded by the Administrator or other ancillary service providers. The bonus is developed and paid by the Administrator or other ancillary service providers based on several aspects of Agent's/Administrator's entire block of business with the carrier or other ancillary service providers.

The undersigned acknowledges receipt of the various proposals and the statement prior to any purchase and approves this transaction on behalf of the Plan without receiving, either directly or indirectly, any personal compensation in connection with the purchase of administration services or policies under the Plan.

_____

Signature of Agent

_____

Name of Plan Sponsor (Employer Group Name)

COBRA ADMINISTRATION ELECTION - Exhibit X – COMPLETE FOR *NEW BUSINESS ONLY*

If you employed 20 or more full and part-time employees for at least 50% of the prior calendar year, you may be required to comply with COBRA (Public Law 99-272, Title X - Continuation Coverage). The Administrator will provide this service for the Plan, if elected. **Complete the Plan election below and submit with the Employer Plan Application.** Refer to the Plan Document for Employer COBRA compliance responsibilities.

Indicate below if the Employer is subject to or exempt from the regulations mandated under the Consolidated Omnibus Budget Reconciliation Act of 1985 known as COBRA:

Complete for new business only – do not complete for renewal business,

_____ Employer is exempt; having less than 20 full and part-time employees for at least 50% of the previous calendar year. *Skip to bottom. Sign, date and return form*.

_____ Employer is subject to COBRA; having 20 or more full and part-time employees for at least 50% of the previous calendar year.

_____ **Employer declines** COBRA administration services. Services performed: Internally by the Employer or outsourced to another administrator.

_____ **Employer elects** COBRA administration services for the calendar year. Employer is responsible to notify the Administrator of all terminations and qualifying events in a timely manner (within 14 days of occurrence). Consequences of untimely notice to the Administrator will be the Employer's responsibility.

Name of Responder Title

Responder's Signature Date

PLAN DOCUMENT SIGNATURE PAGE - Exhibit XI

The Company assures its covered members that during the continuance of the Plan all benefits hereinafter described shall be paid, to or on behalf of them, in the event they become eligible for benefits.

The Plan is subject to all terms, provisions and conditions recited on the following pages hereof. The Plan is not in lieu of, and does not affect any requirements for coverage by Workers' Compensation Insurance.

WITNESSETH

WHEREAS, effective _____, (hereinafter called "Plan Effective Date"), the Company heretofore established a Plan for payment of certain expenses for the benefit of its eligible members known as the _____(Employer Name) Fully-Funded Group Employee Benefit Plan; (hereinafter referred to as the "Plan").

AND

WHEREAS, under the terms of the Plan, the Plan Administrator acknowledges that amendments to the Plan will not be recognized or enforced without prior written approval from the Administrator.

AND

NOW, THEREFORE, it is understood and agreed that: (1) the undersigned has read this Plan in its entirety, has consulted legal and tax counsel to the extent considered necessary, acknowledges that he finds the Plan suitable for his purposes, and further acknowledges that he understands that the Plan has not been the subject of a favorable determination letter from the Internal Revenue Service or any other governmental agencies having jurisdiction over the Plan pursuant to ERISA, and accepts full responsibility for participation hereunder.

PLAN SPONSOR

_____

Legal Name of Employer

_____

Authorized Plan Sponsor Signature

_____

Title

_____

Date

_____

Group Number

NOTES

MID AMERICA

EMPLOYEE BENEFIT ADMINISTRATION

Corporate Office
560 Kirts Blvd., Suite 125
Troy, MI 48084
(800) 482-0945
(248) 585-7900

Mailing Address
P.O. Box 5047
Troy, MI 48007

Mid-America is a Third-Party Administrator servicing Small Businesses for over 50 years.