Enrollment Checklist

1. New Group Enrollment Information Form _____
2. Participation Agreement _____
3. United American Insurance Company Application _____
4. Exhibit E – Certification of Information Relating to Creditable Coverage _____
5. Companion Life Application for Supplemental Prescription Drug Expense Insurance _____
6. Medicare Rx Plan Individual Enrollment Form _____

See Key Contact List for more information, sales and service support

Premier Senior Health Plan

GROUP APPLICATION

CLIENT INFORMATION

Legal Group Name:		Group Tax ID:	
Current address:			
City:	State:	ZIP Code:	Phone:
Contact Person:	Email Address:		

ELIGIBILITY AND UNDERWRITING REQUIREMENTS

Is the current plan fully insured or self-funded?	Number of retirees/spouses:
Are all retirees/spouses over 65 (Y/N)?	Have all retirees been given "retiree status" with employer (Y/N)?
Are all retirees/spouses currently enrolled in Medicare parts A and B (Y/N)?	

PRODUCER INFORMATION

Producer Name:		Producer Agency:	
Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

PLAN INFORMATION

Medical Plan Deductible: *(One Deductible and one Copay option per group)*
Medical Plans are available to groups with one or more enrollees

☐ $0 ☐ $100 ☐ $500 ☐ $1000 ☐ $1500

☐ No Office Visit or Emergency Room Copay
☐ With $10 Office Visit and $50 Emergency Room Copay

Prescription Drug Plan Option: *(One Plan option per group with **TWO** or more enrollees)*

	Plan 1 ☐	Plan 2 ☐	Plan 3 ☐	Custom Plan ☐
Preferred Generic	$0			$ ____
Generic	$15	$5	$0	$ ____
Preferred Brand	$60	$40	$30	$ ____
Brand	$100	$75	$60	$ ____
Specialty	33%	33%	33%	$ ____
Gap Coverage Options (Choose one):	☐ Name Brand & Generic	☐ Generic Only with $0 Deductible ☐ Generic Only with $405 Deductible and Specialty at 25%		

Billing type (list, direct, split):	Number of Full time Employees:	Number of Part time Employees:
Effective Date:	Employer Contribution:	

I attest that all of the above information is accurate and represents the characteristics of this group.

Broker signature:	Date:
Print Name:	Title:
Client signature:	Date:
Print Name:	Title:

PARTICIPATION AGREEMENT
(Rev. 5.15.15)

TO: Trustee of the National Retiree Insurance Solutions Trust (NRIST)
Zions First National Bank. (Pittsburgh, PA), as Successor Trustee, effective May 1, 2015

The Undersigned Employer hereby requests that it be approved as a Participating Employer under The National Retiree Insurance Solutions Trust. The undersigned Employer wants to make certain group insurance coverage under the group insurance policies issued to the Trust is available to its employees or former employees and the spouses of employees or former employees who may be eligible to apply for said coverage.

The undersigned Employer represents that:

1. It has established or is establishing and will maintain an employee welfare benefit plan which includes certain accident and health benefits.

2. The purpose of its participation in this Trust is to obtain the insurance coverage available under policies issued to the Trust in order to continue to provide access for its retirees to certain benefits provided under the policies. The Employer agrees to provide the Administrator with sixty (60) days written notice of its intent to discontinue its participation in the Trust.

3. Unless otherwise provided in plan documents, the benefits available under said plan are identical to and subject to the same terms and conditions as those provided under policies issued to the Trust and applicable to the undersigned Employer.

4. In those cases where it does not pay the entire premium for insurance coverage available through its participation in this Trust, it will endorse the group insurance coverage available to its employees or former employees and spouses of employees or former employees through the Trust.

The undersigned Employer understands and agrees that in no event will the Trustee or administrator of The National Retiree Insurance Solutions Trust be a Plan Administrator or other Fiduciary as to a Participating Employer's employee welfare benefit plan.

The undersigned Employer agrees: (1) that the terms and conditions of said Trust Agreement and any amendments thereto shall be controlling as respects plan administration; and (2) that the terms and conditions of any insurance policies issued to the Trustee covering certain employees or former employees or spouses of employees or former employees of the Employer shall be controlling as respects plan benefits and rates.

The undersigned Employer hereby designates TPG Group, Inc. of Norwalk, Connecticut, as Agent of Record as to the group insurance coverage issued in connection with this Participation Agreement.

The undersigned Employer agrees to allow its present administrator (or other designee) to furnish any information reasonably required by the Settlor, Trustee or Insurer under said Trust in connection with the administration of the Insurance Fund under said Trust including eligibility data.

The undersigned Employer understands that the effective date of any insurance coverage will depend on the term of the policies issued or to be issued to the Trust, and that each eligible individual must apply to and be approved for coverage by the Insurer under said policies. The Employer understands that said group insurance policies issued to the Trust may be amended or cancelled by the Insurer. The Employer further understands that the Settlor may terminate said Trust, and that participation of a Participating Employer and coverage of its Insured Persons may be terminated by the Insurer if the Participating Employer fails to comply with the terms of the Trust, Policies or proposal.

By: Participating Employer – ______________________

By: ____

____
Date

Title: ____
Duly Authorized Officer

The above named Employer is approved as a Participating Employer in The National Retiree Insurance Solutions Trust.

For: National Retiree Insurance Solutions Trust
BENISTAR Admin Services, Inc. (Administrator)

____
Date

By: ____
Donna Wayne

Title: Assistant Secretary

UNITED AMERICAN INSURANCE COMPANY
APPLICATION

Administrative Offices: P.O. Box 8080, McKinney, TX 75070

1. a. **Group Policy Number:** ____

   b. **Policyholder:** National Retiree Insurance Trust

   c. **Enrolling Group:** ____

2. **Group Requested Effective Date:** ______________________________________

3. **Eligible Member of the Group:** Retirees Age 65 and Older Enrolled in Medicare A & B

4. **Eligible Dependents:** Spouses Age 65 and Older Enrolled in Medicare A & B

The Applicant hereby applies for Group Insurance and understands and agrees that insurance applied for shall not become effective until the application for Group Insurance is approved by United American Insurance Company at its Administrative Office.

This application, as it may be amended, will become a part of the Group Policy.

FOR THE ENROLLING GROUP:

Signed by: ______________________________ **Title:** ______________________________

Signature: ______________________________ **Date:** ______________________________

Signed at: ____

EXHIBIT E

CERTIFICATION OF INFORMATION RELATING TO CREDITABLE COVERAGE REQUIREMENT AND LATE ENROLLMENT PENALTY FOR PART D EMPLOYER GROUP WAIVER PLAN

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services ("CMS") and Express Scripts Insurance Co., **S7950** (collectively, the "PDP Organization"), governing the operation of the contract between the PDP Organization and **________________ ("CLIENT")**, an Employer Group Waiver Plan (EGWP), the PDP Organization hereby requests from CLIENT a certification concerning the creditable coverage maintained for the Part D beneficiaries enrolled under the contract with CLIENT ("Enrollees").

CMS REQUIREMENT - Under applicable CMS Part D regulations, 42 CFR 423, CMS Manual Chapter 4, and related guidance as may be amended from time to time: plans, "using the Batch Eligibility Query (BEQ), [must] determine whether the beneficiary was either enrolled in a Part D plan or was covered by an employer receiving the retiree drug subsidy (RDS) since the IEP end date. If the beneficiary was enrolled in a Part D Plan or by an employer receiving RDS or in an employer-sponsored plan providing coverage at least as good as the standard Medicare part D plan since the end of the IEP, such that there is no gap in creditable coverage of sixty-three (63) or more days, [the plan must] report to CMS that the beneficiary had zero (0) uncovered months." This coverage is deemed to be continuous "creditable coverage."

Under the same guidance, plans may secure an attestation from employers and unions such as CLIENT, who enroll groups of retirees into Medicare prescription drug coverage. The attestation must provide that employer/ CLIENT has been maintaining continuous creditable coverage for each applicable retiree for the time during which the retiree was enrolled through CLIENT.

DETERMINATION OF UNCOVERED MONTHS – PDP Organization has identified certain Enrollees who appear to have had a gap(s) in creditable coverage for at least sixty-three (63) days and has determined the number of uncovered months for these Enrollees pursuant to the CMS applicable guidelines. The number of uncovered months is listed below. CLIENT is requested to (i) verify whether each listed Enrollee had uncovered months or creditable (continuous) coverage during the months indicated in this document and (ii) complete this Attestation by affixing its signature at the bottom of the document.

ATTESTATION - CLIENT attests by affixing its signature below that all Enrollees submitted by the SPONOR to ESIC for enrollment under an Enhanced Plan were either enrolled under another Prescription Drug Plan or had other creditable coverage as defined by the CMS applicable guidelines prior to their coverage under Enhanced Plan

ACCURACY – In providing said Certification, CLIENT acknowledges that the information directly affects the calculation of CMS payments to the PDP Organization and/or CLIENT or

additional benefit obligations of the PDP Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

RESPONSIBILITY – CLIENT will indemnify and hold ESIC harmless from claims or causes of action asserted against ESIC arising from misrepresentation of information provided in this Attestation by CLIENT.

APPEAL – ESIC shall not be responsible for appealing CMS' determination of Enrollees' creditable coverage status, however, ESIC shall honor the final disposition of appeals that are filed by CLIENT.

AGREEMENT – This Attestation supplements and is made a part of the Agreement in effect between ESIC and CLIENT.

Based on best knowledge, information, and belief, as of the date indicated below, CLIENT is attesting that all information submitted to PDP Organization in this report is accurate, complete, and truthful.

Name:_______________________________

Title:________________________________
on behalf of CLIENT

Date: _______________________________

COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251
(the “Company”)

APPLICATION FOR
SUPPLEMENTAL PRESCRIPTION DRUG EXPENSE INSURANCE

Name of Group:____

Address:

____
(Street)

____
(City) (State) (Zip)

applies to the Companion Life Insurance Company, for a supplemental prescription drug expense policy.

If the Insurance Company approves this application, a policy will be issued. The group agrees that acceptance of the policy will be an approval of the policy terms.

Policy Effective Date: _________________________

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND/OR CIVIL PENALTIES.

DATED ON ______________________________ GROUP ______________________________

AGENCY ______________________________ BY ______________________________
PRINT agency name — Group Representative Signature and Title

AGENT ______________________________ ______________________________
PRINT agent name — ***PRINT*** group representative name

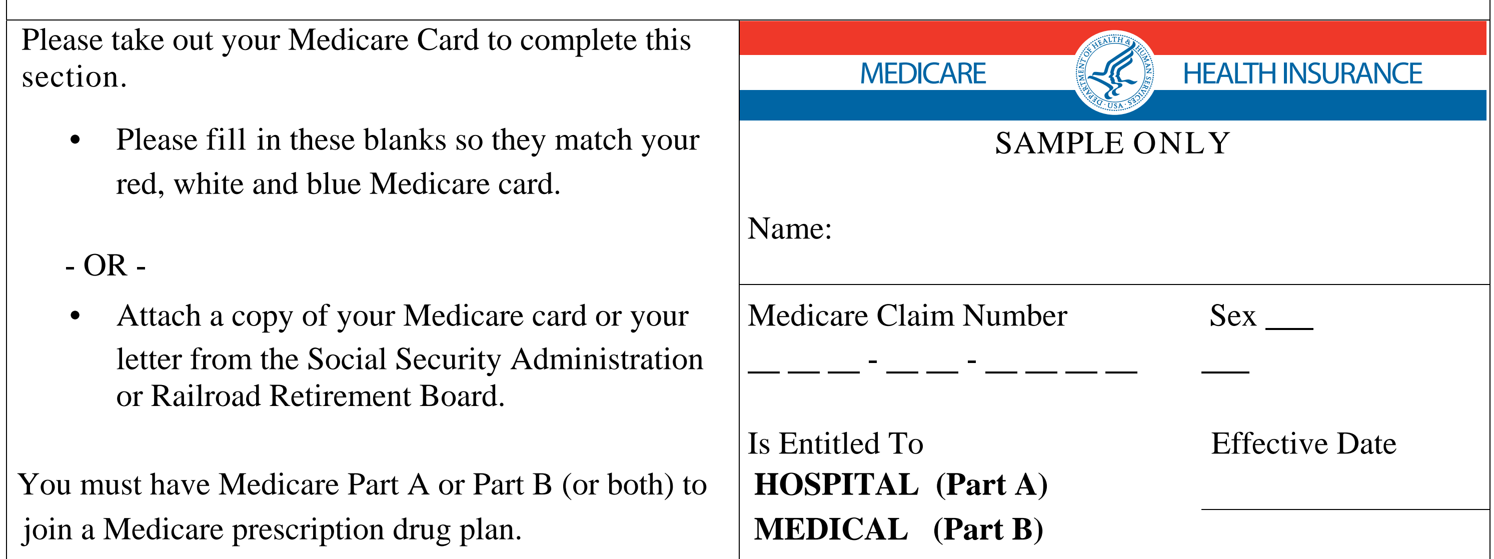
______________________________ ______________________________
Agent signature here — Witness signature here

INDIVIDUAL ENROLLMENT FORM
EMPLOYER-SPONSORED GROUP PLAN ADMINISTERED BY BENISTAR

Desired Effective Date: ____________________

LAST name:	FIRST Name:		Middle Initial:	Mr. Mrs. Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	Social Security Number:		Home Phone Number: ( )
Permanent Residence Street Address:				
City:		State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:				
Emergency contact: [Optional]				
Phone Number: [Optional]____________________ **Relationship to You** [Optional] _______________				
E-mail Address: [Optional]				

Please Provide Your Medicare Insurance Information



Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Medicare Claim Number __ __ __ - __ __ - __ __ __ __

Sex ___ ___

Is Entitled To

HOSPITAL (Part A)

MEDICAL (Part B)

Effective Date

Signature:	**Today's Date:**

Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare™ (PDP) is offered by Medco Containment Life Insurance Company, Medco Containment Insurance Company of New York and Express Scripts Insurance Company, which contract with the Federal government. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1 of each year.

Release of Information

By joining this Medicare prescription drug plan, I acknowledge that Express Scripts Medicare can release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
I also acknowledge that Express Scripts Medicare can release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

© 2013 Express Scripts Holding Company. All Rights Reserved.