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)*

Plans including Rx, enrollment must be submitted a minimum of 50 days prior to the requested effective date. Custom plans only available to groups of 6 or more.

	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 **$445** 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:

Premier Senior Health Plan
11649 N Port Washington Rd Suite 200, Mequon WI
53092 (855) 344-7747 | info@pshp.net

EXHIBIT C

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 PDP Sponsor"), governing the operation of the contract between PDP Sponsor and Client, an Employer Group Waiver Plan (EGWP), PDP Sponsor 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 Enrollee 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 Enrollee 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 Enrollee 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 Enrollees into Medicare prescription drug coverage. The attestation must provide that employer/Client has been maintaining continuous creditable coverage for each applicable Enrollee for the time during which the Enrollee was enrolled through Client.

Attestation

Client directs PDP Sponsor to effectuate enrollment into an EGWP of all persons on such files. In doing so:

- ☐ For persons on the initial file and subsequent files, Client attests that all Enrollees submitted by the Client to PDP Sponsor 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. This Attestation applies to all enrollees Client has submitted to PDP Sponsor as of the date below, and shall further apply as a continuing obligation to submissions by Client at any time during the term of the Agreement.
- ☐ For the initial file, Client attests that all Enrollees submitted by the Client to PDP Sponsor 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.
- ☐ Client will not attest on behalf of Enrollees submitted by Client to PDP Sponsor regarding whether Enrollee's prior enrollment under another Prescription Drug Plan met CMS defined creditable coverage criteria.

RELEASE TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) - PHI is collected by Express Scripts, Inc. and its affiliates ("ESI") in connection with the prescription drug program of Client which is administered by ESI pursuant to ESI's arrangement with Client. Pursuant to the Standards for Privacy of Protected Health Information ("Privacy Rule") to the Health Insurance Portability and Accountability Act of 1996, Client represents and warrants that PDP Sponsor may access information pertaining to the commercial coverage, which includes RDS coverage of the Enrollees for the purpose of verifying whether Enrollees had creditable prescription drug coverage during the coverage gap assessed by the PDP Sponsor pursuant to the Chapter 4 – Creditable Coverage Period Determinations and the Late Enrollment Penalty - of the Medicare Prescription Drug Benefit Manual requirements.

ACCURACY – In providing said Certification, Client acknowledges that the information directly affects the calculation of CMS payments to the PDP Sponsor and/or Client or additional benefit obligations of PDP Sponsor and those 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 PDP Sponsor harmless from claims or causes of action asserted against PDP Sponsor arising from misrepresentation of information provided in this Attestation by Client. Client agrees to provide PDP Sponsor proof of creditable coverage or documentation from members in the event that PDP Sponsor is audited by any government authority.

APPEAL – PDP Sponsor shall not be responsible for appealing CMS' determination of Enrollees' creditable coverage status, however, PDP Sponsor 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 PDP Sponsor and Client.
Based on best knowledge, information, and belief, as of the date indicated below, Client is attesting that all information submitted to PDP Sponsor is accurate, complete, and truthful.

Signature: _____

Print Name: _____

Client: _____

Dated: _____

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