Enrollment Checklist

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

* Groups enrolling in Medical and Rx, enrollment material must be submitted a minimum of 50 days prior to the requested effective date

* Groups enrolling in Medical only, enrollment material must be submitted a minimum of 30 days prior the

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 $505 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
(888) 344-2522 | info@hismi.com

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 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: ________________________