



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 50 days prior to the requested effective date.

*Groups enrolling in Medical only, enrollment material must be submitted 30 days prior the requested effective date.

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 <input type="checkbox"/>	Plan 2 <input type="checkbox"/>	Plan 3 <input type="checkbox"/>	Custom Plan <input type="checkbox"/>
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):	<input type="checkbox"/> Name Brand & Generic <input type="checkbox"/> Generic Only with \$0 Deductible <input type="checkbox"/> Generic Only with \$415 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 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 Express Scripts Insurance Co. (“MCLIC”), governing the operation of the contract between MCLIC and _____ (“Client”), an Employer Group Waiver Plan (EGWP), MCLIC 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 MCLIC 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 MCLIC 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 MCLIC 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 MCLIC 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.

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 MCLIC 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 MCLIC 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 MCLIC and/or Client or additional benefit obligations of MCLIC 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 MCLIC harmless from claims or causes of action asserted against MCLIC arising from misrepresentation of information provided in this Attestation by Client. Client agrees to provide MCLIC proof of creditable coverage or documentation from members in the event that MCLIC is audited by any government authority.

APPEAL – MCLIC shall not be responsible for appealing CMS' determination of Enrollees' creditable coverage status, however, MCLIC 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 MCLIC and Client.

Based on best knowledge, information, and belief, as of the date indicated below, Client is attesting that all information submitted to MCLIC 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 _____
PRINT agency name

BY _____
Group Representative Signature and Title

AGENT _____
PRINT agent name

_____ ***PRINT*** group representative name

Agent signature here

Witness signature here

**MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
SPONSORED GROUP PLAN**

**To enroll in Express Scripts Medicare® (PDP)
please provide the following information:**

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

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card. <p align="center">- OR -</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	<p>Name: _____</p> <p>Medicare Number _____ - _____ - _____</p> <p><u>OR</u> Medicare Claim Number _____ - _____ - _____</p> <p>Is Entitled To Effective Date</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>
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Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare® (PDP) is offered by Medco Containment Life Insurance Company, which contracts 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.

Enrollment Requirements

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 must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

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.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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.

Signature:

Today's Date:

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

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