National General Benefits Solutions

Employer Stop-loss Implementation Questionnaire
National General Benefits Solutions
Self-Funded Program

Instructions for completing this agreement:
1) The employer or employer representative must complete the entire Questionnaire with signature.
2) The agent must sign and date this agreement.

Requested effective date:____/____/____ (Must be 1st or 15th*, date subject to underwriting approval)
*Note Cigna and Meritain POS do not allow the 15th of the month effective dates

SECTION A - Employer Information

1. Company Name: _____
Full legal name of Company
Doing business as (dba):_____

2. Employer address: _____
Street
_____
City County State Zip
Mailing address:_____
(If different) Street City State Zip

3. Phone number: (___)_____ Fax number (___) _____
4. Contact Person and Title: _____
5. Email address: _____
By providing your email address you agree that you may receive your policy and/or certificate of issuance and other correspondence electronically.
6. Owner (s) Name (s): _____
7. Nature of Business/SIC Code: _____
8. Type of ownership/filing status: ☐ Proprietorship ☐Partnership ☐C-Corporation
☐ S-Corporation ☐Government ☐ Other (please specify) _____

9. Federal Tax Identification Number: _____
10. How long has the company been in business? _____
11. Employer Contribution to premium *(must be a minimum of 50% of employee's premium)* Medical_____%
12. Waiting/Affiliation period (the length of time future employees must be employed before becoming eligible for coverage):
☐0 days ☐30 days ☐ 60 days ☐ 90 days
Note: the effective date will be on the first day of the billing cycle following the date the employee satisfied their waiting period and they enrolled for coverage within 31 days of becoming eligible for coverage.
13. Are you waiving the groups waiting/affiliation period for all employees for the group's original effective date?
Note: Groups with 25 or more enrolling employees cannot waive the waiting period
☐Yes ☐No

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SECTION B - Benefit Information

1. Will this plan replace other group coverage? ☐ Yes ☐ No
   a) If Yes, is your current plan a Major Medical Plan ☐ Yes ☐ No
   b) If Yes, is your current plan a Fully Insured or Self-Funded Plan ☐ Fully Insured ☐ Self-Funded
   c) Please provide 12 months of information below and provide a copy of your most recent medical billing statement.

Prior Medical Carrier(s)	Policy Number	Effective Date	Termination Date

2. Will you be or are you offering another group medical plan in addition to this group plan? ☐ Yes ☐ No
3. Please select your Run-out Period (note Core Value Plans will be assigned a 9 month run out) ☐ 6 months ☐ 12 months
4. Select one ☐ Plan Year Deductible ☐ Calendar Year Deductible
5. Did you employ 20 or more full-time equivalent employees for at least 50% of the previous calendar year? ☐ Yes ☐ No
6. COBRA enrollment
   a) Do you want to offer COBRA if your current or future group size does not require this ☐ Yes ☐ No
   b) Please indicate your COBRA Administrator (If none selected, National General Benefits Solutions or the TPA will administer): ☐ National General Benefits Solutions ☐ Other _____
7. Cigna/Meritain business only: Are any of your employees selecting Vision or Dental benefits ☐ Yes ☐ No
8. Cigna/Meritain POS only (HSA Option): Will you be offering employees a Health Savings Account? ☐ Yes ☐ No
   a) If Yes, please indicate your HSA Administrator (if none selected, National General Benefits Solutions or the TPA will administer): ☐ National General Benefit Solutions ☐ Other _____

SECTION C - Affiliated Companies and Multiple Locations

1. Do you have any employees that reside in CA or NC? ☐ Yes ☐ No
2. Does your company have other business organizations under common ownership or more than one Federal Tax ID Number? ☐ Yes ☐ No
3. Does your business have more than one physical location ☐ Yes ☐ No

If "Yes" to either question, complete the following: Indicate the number of full-time (FT) and part-time (PT) employees' whether enrolling or not (based on the eligible employee requirements Section D).

Business Name	Address	Owner (s)
Nature of Business	Tax ID	(FT) (PT)
Business Name	Address	Owner (s)
Nature of Business	Tax ID	(FT) (PT)
Business Name	Address	Owner (s)
Nature of Business	Tax ID	(FT) (PT)

Stop-loss Insurance for the National General Benefits Solutions Self-funded Program is underwritten by National Health Insurance Company, Time Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.

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SECTION D - Employee Information

All eligible full-time employees, including those in the new employee waiting period, must submit an Enrollment form or Waiver of Coverage form. If additional employees are hired between the date this application is completed and the date coverage is issued, completed Enrollment forms or Waiver of Coverage forms must be submitted within 5 days of the date of hire.

1. Total number of employees (including owners, partners, etc.) working in your business _____
2. How many are full-time employees? _____
3. How many are part-time employees? _____
4. Are any former employees or dependents on or eligible to elect Continuation (COBRA)..... ☐ Yes ☐ No

Name	Start Date	End Date	Type of Continuation	Reason

5. Are any employees currently absent due to illness or injury? Family Medical Leave or receiving Disability benefits?..... ☐ Yes ☐ No
   If Yes, provide employee name(s) and details _____

Eligible Employees

An eligible employee must meet the following requirements: a) performs services on a full-time basis; b) be considered an employee for federal employment tax purposes at any of the employer's business establishments (including all affiliated businesses listed in Section C); and c) be 18 years old.

The Employer may select the number of hours (between 20 and 40) an employee must work each week in order to be considered full-time and eligible for coverage. If the employer does not select a full-time eligibility requirement, eligibility will be administered based upon 30 hours per week.

1. Indicate the eligibility requirement between 20 and 40 hours per week _____
2. Complete the census below listing each eligible employee name and indicate whether enrolling or waiving.

	Employee Name:	*E=Enrolling W=Waiving*			Employee Name:	*E=Enrolling W=Waiving*
1				*16*		
2				*17*		
3				*18*		
4				*19*		
5				*20*		
6				*21*		
7				*22*		
8				*23*		
9				*24*		
10				*25*		
11				*26*		
12				*27*		
13				*28*		
14				*29*		
15				*30*		

If additional space is needed, please provide additional information on a separate sheet of paper.

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SECTION E - Agreement

I will adhere to the contribution rules of National General Benefits Solutions regarding my contribution toward the employee cost of coverage and that stop loss coverage may be terminated if the contribution falls below the minimum contribution requirement; all employees currently working for me are compensated in a manner that complies with all applicable federal and state requirements; all eligible employees must enroll now and in the future according to the participation rules of National General Benefits Solutions and that coverage may be terminated if the percentage falls below the participation requirements; National General Benefit Solutions reserves the right to request a state wage and tax statement or other documentation at any time to verify current and future participation and eligibility; the monthly maximum cost is subject to change until all of the following have occurred: a) the stop loss coverage has been approved by National General Benefits Solutions; (b) notice of effective date for the stop loss coverage has been furnished by National General Benefits Solutions; and (c) the first invoiced amount due for premium and services provided under the Program is paid; (d) I must give notice to the third party administrator within 30 days of any participating employee who ceases working the established eligible hours as defined on this application, including, but not limited to those on paid or unpaid leave, disability, salary continuation or worker's compensation.

I hereby agree to be bound by all the terms and conditions of the Program, including the terms and conditions outlined in the stop loss policy. I understand that the benefits I have selected for my self-funded group health plan are reflected on the attached signed proposal which is part of this request for participation in the Program.

As the participating employer or person acting with the authority of the participating employer, I certify that this information is complete and true to the best of my knowledge and belief. I fully understand that participation in the Program, including coverage under the stop loss policy, is not effective without the approval of National General Benefits Solutions. It is further understood that no agent has the authority to alter or amend any Program agreements, the self-funded health benefit plan I have established, or the stop loss policy, to adjust any claim for benefits, or to bind National General Benefits Solutions by making any promise or representation. I understand that any material misstatement and/or omissions may void or terminate participation in the Program, including stop loss coverage.

By signing below, I certify that I have read the entire Employer Application, agree to all terms and conditions contained therein and that all information provided is true and accurate.

Signature_____ Title _____

Printed Name of Employer_____ Date_____

Send your completed application and other required documents to your sales office. Underwriting may request that the employer provide additional documentation (e.g. Payroll Records, business License, etc.) during the underwriting process or at any time while coverage is provided.

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SECTION F - Agent Statement

I certify that all of the information contained in the Implementation Questionnaire and any additional documents are correct the best of my knowledge. I have complied with all of the underwriting rules and have fully explained the Program and stop loss coverage to the employer.

Agent Signature:_____ Date:_____

Print Agent Name: _____ Agent#:_____

Agent Address:_____ Agent Phone# _____

SECTION G - Distribution Partner Information

Complete all applicable fields

Office Name: _____ Date: _____

Representative Name:_____ Representative#: _____

Representative Phone#: _____ Representative Fax#: _____

Email Address:_____