Health Program Participation

Request/Contract

Section 1 Member Information

Member Name _____

Federal Tax ID Number _____

Address _____ Phone # _____

City, State, Zip Code _____ Fax # _____

Email Address _____

Broker Name _____

Section 2 Billing Information *(If Different from Above)*

Billing Address _____ Phone # _____

City, State, Zip Code _____ Fax # _____

Billing Contact Name _____

Section 3 Billing & Collections Guidelines

Initial Contract for the Member, as stated in Section One (1) and incorporated herein by reference, shall remain in force for twelve months from the Effective Date of Coverage ("Effective Date") unless terminated pursuant to the terms and conditions contained herein. Unless otherwise agreed to in writing by Triad Benefits, LLC. ("Program"), the Effective Date shall always be the first day of the month. Any subsequent Contracts for Renewal of Coverage ("Renewal Contracts") shall remain in force for subsequent periods of twelve (12) months unless terminated by the Member or the Program. Payment of money to cover the cost of Health Benefits ("Healthcare Fees") shall be remitted to the Program monthly, accounted for separately and after all administrative expenses, the remaining balance shall be designated as the member-group's claims fund account, subject to the following guidelines for Billing and Collections:

1 Billing shall be based on the current census of members and dependents that are on record with the Program, as of the date on which invoices are generated. Member understands that any changes to their census may result in changes to their healthcare fees.

2 Each month, you will receive your invoice via email. Payment is due on the 1st of each month and will be collected on or about the 1st day of each month and considered late if not paid by the 30th of the month, at which time the group will be subject to termination if not paid in full.

3 Unless notified otherwise by the Program, monthly healthcare fees shall be drafted via Automated Clearing House ("ACH") on, or around, the 1st business day of each month from a bank account designated by the Member for purposes of pulling healthcare fees. If insufficient monies are available in the account, the Member shall experience a suspension in the payment of claims. Said suspension shall continue until the Member's designated account has enough monies to correct the delinquency, at which point the Member's account can be considered current.

4 Member agrees to reimburse the Program for any claims incurred and or paid during any period of delinquency, including, but not limited to, additional expenses that may be assessed due to late and or non-payment. If a group or member terminates this contract prematurely, they will be responsible for an additional 3 months of healthcare fees as a penalty and to cover potential run-out of the early termination.

5 Any Member that fails to remit healthcare fees by the 30th day of the then-current month shall be terminated from the Program. If payment of healthcare fees is received within the original due date ("Grace Period"), then the Member's participation in the Program may be reinstated, without a break in coverage. All reinstatements are subject to review, potential rerate and/or declination.

6 Member understands and agrees that the Program may modify health care fees based on Member's experience, utilization and/or demographic change.

7 At the Program's discretion, any Member that is terminated from the Program for non-payment of healthcare fees may resume participation in the Program once all outstanding healthcare fees are paid in full, if reinstatement has been approved.

8 Member and dependent terminations must be sent to the Master General Agent ("MGA") or TPA using the appropriate form(s) at least fifteen (15) days ("Minimum Notice") prior to the requested date of termination. Member understands that any failure to provide this Minimum Notice will result in a termination delay, which will be no less than thirty (30) days. Member understands and agrees to remain liable for payment of healthcare fees for those experiencing a termination delay.

By signing this Request/Contract in Section Thirteen (13), the Member agrees to the "Billing and Collection Guidelines," as described herein, and understands that failure to do so shall result in the termination of this Request/Contract. Furthermore, the Member understands and agrees they shall remain liable for the healthcare fees due to the Program, even if this Request/Contract is terminated by the Program for non-payment of healthcare fees.

Section 4 Requested Effective Date

Requested Effective Date: _____,20___

Member: In the space above, please indicate the month in which you would like for coverage from the Program to begin. This date is a non-binding request that is contingent upon receipt of all quoting/enrollment materials and subject to the Program's acceptance of this Request/Contract. Once accepted, the Member will provide notification of your actual Effective Date, which shall only be on the first day of any given month.

Section 5 Program Type & Member Coverage

Member hereby requests participation as indicated on the Member's Program Selection, as shown in Section Twelve (12), which is incorporated herein by reference.

Section 6 Healthcare Fees and Contract Terms

Members seeking first-time coverage from the Program ("New Groups") agree that healthcare fees assessed pursuant to Initial Contracts shall remain in force for 12-months from the effective date unless otherwise modified by the Program. New Groups shall be construed to include any Member that had previously lost coverage from the Program as the result of any failure to remit payment of healthcare fees before the end of the Grace Period.

Upon conclusion of an Initial Contract, Members may continue their coverage with the Program for subsequent periods that are no less than twelve (12) months. Unless otherwise modified by the Program, healthcare fee amounts assessed pursuant to Renewal Contracts remain valid from effective date of coverage for 12-months or the terms of their contract. Members that remit payment for healthcare fees as due on the Renewal Date will be deemed to have accepted the Renewal Contract. Unless otherwise notified by the Program, Members understand and agree that the terms and conditions of Renewal Contracts are the same as those in effect for the Initial Contract. Members agree the Program reserves the right to adjust healthcare fees during Initial and or Renewal Contracts if the claims expense and or Program utilization exceeds projections.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, agrees to all the terms and conditions contained herein.

Section 7 Termination of Contract

Member may terminate this Request/Contract upon renewal.

Member agrees that the Program reserves the right to modify, terminate, or rescind this Request/Contract back to the original Effective Date if any member intentionally provides the Program with inaccurate information about their health or the health of their dependents during the underwriting process. Rescind means that the coverage was never in effect. Should this Request/Contract be rescinded, the Member agrees to accept liability for all claims that have been incurred by their members or dependents of their members but not paid.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, agrees to all the terms and conditions contained herein.

Section 8 Summary of Benefits and Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health programs, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to compare options and select health plans easily. Members can access SBC's by visiting Triad.health. A hard copy of the SBC can also be provided upon request. For more information regarding this healthcare reform provision, visit www.healthcare.gov.

Section 9 Underwriting Guidelines

Underwriting Guidelines, as established by the Program, shall be enforced while all Initial and Renewal Contracts are in force and shall continue to do so unless the Member is notified otherwise by the Program. The Underwriting Guidelines are incorporated herein by this reference.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, agrees to be bound by the Program's Underwriting Guidelines.

Section 10 Program Elections

Plan year (from effective) or Calendar Year:

☐ Plan Year ☐ Calendar Year

COBRA Election:

☐ By TPA ☐ By Outside Vendor

Employer Contribution:

	Percentage	Flat Rate
Employee Only	_____	_____
Employee + Spouse	_____	_____
Employee + Child	_____	_____
Employee + Family	_____	_____

Section 11 Conditions of Participation

Member further agrees that:

1 For coverage to go into effect, the Member's Request/Contract must be accepted by the Program.

2 For coverage by the Program to remain in force, the Member must: (1) be an eligible member of Triad Benefits, LLC when applying for participation in this Program; (2) meet program membership requirements established by the governing documents of Triad Benefits, LLC including working full time (defined as working 30- hours or more per week), the program reserves the right to request wage and tax as verification and under 65 years of age; (3) remain a member in good standing of Triad Benefits, LLC.

3 The Member has seen a copy of the benefits proposed and agrees to remit all applicable healthcare fees to the Program as outlined in Section Three (3). Member further agrees to allow all eligible members an opportunity to enroll for coverage.

4 The member/group understands that even after their group health applications have been rated and approved, it is the members responsibility to notify the Program of any health changes prior to the approved effective date. Failure to do so could be considered a misrepresentation of health facts and result in coverage and any claims incurred being denied or rescinded. This is at the sole discretion of the Program.

5 At all times, the coverage is subject to the benefit plan applied for by the Member, which alone constitutes the Contract under which benefits become payable.

6 By executing this Request/Contract and depending on the number of employees to be enrolled by the group or member, Member understands that the Member has joined Triad Benefits, LLC and the Member is entitled to exercise rights to receive all products and services offered by Triad Benefits, LLC to Members.

7 Member understands and agrees that the Program may not renew health care coverage which determination is left to the sole discretion of the Program.

8 Member agrees that the Program shall not be liable for any health care claims incurred by any Member(s) and or Dependent(s) after the date on which coverage was terminated. Member agrees to reimburse the Program for covered charges which were incurred by any Member(s) and or Dependents(s) after the date on which coverage was terminated. Member further agrees to provide the equivalent of 90-days of healthcare fees should the member terminate this agreement before the end of the initial term or the renewal term.

Acceptance of this Request/Contract by the Program is subject to the Member's willingness to be bound by the Program's requirements. For purposes of this Section, these requirements include the provisions of any Administrative Services Agreement between the Program and its TPA, but only to the extent, such provisions apply to rights and or obligations of Members that participate in the Program.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, hereby requests participation in the Program and agrees to be bound by all the terms and conditions contained herein.

Section 12 Member Plan Selection

INSTRUCTIONS:
STEP 1: Select your Medical Plan Option - You can select one plan, or any combination of the multiple medical plan options offered so long as they follow the following guidelines:

- 1-5 employee groups can choose 1 plan
- 6-10 employee groups can choose 2 plans,
- 10 - 25 employee groups can choose 3 plans,
- 25 - 50 employee groups can choose 4 plans,
- 50+ employees groups can choose 5 plans.

STEP 2: Member Selection - Send a signed census identifying which plans and what tier (e.g., family, EE, etc.) currently covered members are choosing. Otherwise, plan implementation cannot move forward, and you will experience a delay.

Note: Please ensure you fully understand the Program Benefits you are enrolling in, as you can only change your selections during the Plans Open Enrollment. Be advised that if you select a plan option that has no enrollment at the inception of the plan, that plan option will not be available after the effective date.

Medical Plan Options Check your selected plan(s)

☐	Plan #1 $1,000 Individual deductible	$2,000 Family Deductible
☐	Plan #2 $1,500 Individual Deductible	$3,000 Family Deductible
☐	Plan #3 $2,500 Individual Deductible	$5,000 Family Deductible
☐	Plan #4 $3,500 Individual Deductible	$7,000 Family Deductible
☐	Plan #5 $5,000 Individual Deductible	$10,000 Family Deductible
☐	Plan #6 $7,350 Individual Deductible	$14,700 Family Deductible
☐	Plan #7 $3,500 HSA - $3,500 Individual Deductible	$7,000 Family Deductible
☐	Plan #8 5,000 HSA - $5,000 Individual Deductible	$10,000 Family Deductible

Waiting Period – 1st of the Month following:
☐ 0 days of employment
☐ 30 days of employment
☐ 60 days of employment

Network Selected:

☐ Cigna ☐ RBP

Section 13 Member Attestation and Signature

Member hereby acknowledges and understands that (1) all enrolled members must meet all the Program's terms and conditions, outlined herein; (2) waivers must be provided for all members waiving coverage; and (3) absent a Qualifying Life Event, as defined in 26 CFR 1.125-4, members and any of their respective dependents are not permitted to make changes until the next open enrollment period, as established by the Program.

Member takes full responsibility that the information provided to the Program by its members and any of their respective dependents is accurate. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for health coverage is guilty of a crime.

Authorized Representative of Member (Name) _____

Authorized Representative's Signature _____ Date _____

Broker Representative: _____