



Employer / Sponsor Application to establish an ERISA Health & Welfare Benefit Plan

**AMERICAN
BENEFIT
ADMINISTRATIVE
SERVICES, INC.**
1733 Park Street, Suite 300
Naperville, IL 60563
(800) 736-7872

EMPLOYER / SPONSOR DATA

1. Full Legal Business Name/Plan Sponsor _____ (herein "Plan" or "Plan Sponsor")
2. Type of Business: Corporation Partnership Sole Proprietorship LLC Non-Profit Other _____
3. Street Address _____ City _____ State _____ ZIP _____
4. Mailing Address (if different) _____ City _____ State _____ ZIP _____
County _____ Phone _____ Fax _____ E-Mail _____
5. Nature of Business _____ Date Business Started _____
6. Federal Tax ID No. _____ SIC Code _____
7. Administrative Contact Person _____ Phone _____ E-Mail _____
8. Executive Contact Person _____ Phone _____ E-Mail _____
9. Names/Addresses of locations/subsidiaries/affiliates: _____
10. Does firm have Workers' Compensation? Yes No If yes, name of carrier: _____
11. Is group plan now in effect with another carrier? Yes No
If yes, give name of carrier and policy _____ On what date will your present plan terminate: _____
DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED, IN WRITING, OF ACCEPTANCE OF THIS COVERAGE.
12. Is anyone in your firm currently under COBRA, state continuation plan, or within their election period? Yes No
If yes, please list below (Note: Any COBRA applications received after approval may result in a Monthly Contribution Amount adjustment.)

Employee/Dependent Name	Termination Date of Original Coverage	Qualifying Event

EMPLOYEE DATA

1. Total number: Full-Time Active employees: _____ Part-Time Employees: _____ Eligible Employees: _____
2. Minimum hours (per week) required for eligibility: _____ Total number of Enrolling Employees: _____
3. Employee probationary period: 30 days 60 days 90 days Other _____ (Minimum - 30 days)
4. Is the probationary period waived on the effective date of the group plan? Yes No
*Coverage will be effective on the first of the month after the probationary period.
Employee terminations will be effective at the end of the month during which coverage was terminated.*
5. Percentage of Employer Contributions: _____% Employee Coverage _____% Dependent Coverage
(At least 75% of eligible employees not covered elsewhere must enroll)

PLAN SELECTIONS

1. **PLAN SELECTION:** (Please fill in plans being offered to your employees, up to 4)

PLAN Option 1	PLAN Option 2	PLAN Option 3	PLAN Option 4
Plan Name:	Plan Name:	Plan Name:	Plan Name:
Deductible:	Deductible:	Deductible:	Deductible:
Co-Insurance/Stop-Loss:	Co-Insurance/Stop-Loss:	Co-Insurance/Stop-Loss:	Co-Insurance/Stop-Loss:

2. A \$50 billing fee will be charged each month.
3. PPO Network: _____
4. Life/AD&D Insurance – Minimum \$15,000 / Maximum \$100,000
Life amount reduces beginning at age 65 as shown in the policy

<u>Class Description</u>	<u>Amount</u>
Class 1 _____	_____
Class 2 _____	_____
Class 3 _____	_____

FUNDING OBLIGATION

The undersigned acknowledges that the Monthly Aggregate Amount (consisting of monthly claims liability plus monthly fixed cost) will be remitted to American Benefit Administrative Services, Inc. (ABAS) each month. The undersigned acknowledges that this Monthly Aggregate Amount will include the medical claims liability, administrative expenses, fees, commissions, any compensation, and the purchase of Excess Loss Insurance for the contract period. The undersigned acknowledges and understands that if at any time funds have not been provided and there are not adequate funds available for my eligible medical claim liabilities, payment for claims will not be made.

IMPORTANT: Termination of the Administrative Services Agreement for any reason before the end of the annual contract term, as set forth in the Administrative Services Agreement, will immediately terminate any Excess Loss Insurance then in effect. In such an event, the undersigned understands that any and all Plan liabilities in excess of the Plan's Active Claims Liability Fund (*as determined by ABAS*) will be the sole responsibility of the Plan Sponsor. Generally, the Plan's Active Claims Liability Fund is the amount available out of the paid Monthly Aggregate Amount for the payment of Plan liabilities after all of the above referenced fees, payments for coverage(s), compensations, commissions and any and all expenses are paid in full. The Administrative Services Agreement will be terminated immediately without further payment if funds are not remitted as required after notification by ABAS. The Employee Retirement Income Security Act (ERISA) places a fiduciary responsibility on the employer, as Plan Sponsor, to ensure the Plan is adequately funded. ABAS may notify all Plan Participants if your claims account is determined to be in jeopardy. (*This is only a summary or general description of the funding being offered. You should refer to the Administrative Services Agreement by and between the undersigned and ABAS for a more particular description of the Monthly Aggregate Amount and the terms and conditions thereof.*)

EFFECTIVE DATE / DEPOSIT

Requested effective date _____ Deposit with Application \$ _____
Make check payable to: (Employer/Sponsor Name) Health & Welfare Benefit Plan

IMPORTANT: No action is taken on the Employer/Sponsor Application until after all required information is submitted. Final Monthly Aggregate Amount is based on actual enrollment. The Plan Options selected are subject to underwriting and the proposed Monthly Aggregate Amount is subject to change or declination. In such an event, the increased Monthly Aggregate Amount proposed under your Plan will be submitted to you as soon as practicable for your approval. The deposit amount will be returned to the applicant if the application is declined. No person other than an officer of ABAS has the authority to bind or alter benefits and the undersigned agrees that any such attempt by the servicing representative is void and is not effective. **Benefits are not effective until the undersigned receives written approval from ABAS. Until such time, Employer agrees not to terminate present coverage.**

APPLICANT AGREEMENT

The servicing representative has explained the details of the coverage(s)/benefits and the undersigned acknowledges reading this entire application. The undersigned states and affirms that the answers provided herein are true and complete. The undersigned acknowledges that the statements contained herein are being relied upon by ABAS in determining whether to enter into an Administrative Services Agreement with the undersigned and/or Plan Sponsor. The undersigned acknowledges that the terms and conditions herein bind the applicant and ABAS **only** when the applicant receives written approval from ABAS and the parties have executed a definitive Administrative Services Agreement in an exact form as provided by ABAS. The undersigned, Employer and/or Plan Sponsor, understands that this is a Self-funded health plan and the administration is provided through a Plan Administrator. This means that the risk of medical expenses and/or Plan Liabilities is assumed by the Plan rather than an insurance company. If accepted by ABAS a portion of your Monthly Aggregate Amount will be paid to an Excess Loss Provider to purchase Excess Loss Insurance. Such Insurance will assume a portion of your Plan's medical claims risk up to its limits of liability. Employers who choose to self-fund an employee benefit plan must comply with the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Dated at _____ Dated on _____
(City & State) (Month, Day, Year)

Full Legal Business Name _____

Signature _____
(Must be signed by a person authorized to purchase benefits for this firm)

Print Name and Title _____

Mail Summary Plan Description (SPDs) and Identification (ID) cards to: Employer's Business Address Agent's Address

SERVICING REPRESENTATIVE INFORMATION

Servicing Representative _____ SS # or EIN # _____

Street _____ City _____ State _____ ZIP _____

Telephone Number _____ Fax Number _____

I have explained to the Employer that final Monthly Aggregate Amount is based on actual enrollment and that the Plan options selected are subject to underwriting and the proposed Monthly Aggregate Amount is subject to change or declination. I have notified the employer not to terminate present benefits until notified in writing by American Benefit Administrative Services, Inc. of acceptance of this application. I have presented to the Employer the SET New Business Disclosure Form.

Signature of Servicing Representative: _____ Date _____

TPA USE ONLY

Effective date _____ Approved by _____ Date _____

Comments _____