The Defend Plans

AcuityGroup

New Group Submission Checklist

Group Name:_____ Contact:_____

Contact Email:_____ Contact Phone:_____

Thank you for selecting the Defend Plans. Please email as attachments the following forms to Sales@InsurgencyBenefits.com.

	For Employers and Employees
☐	**Employer Application** Please be thorough and do not leave questions blank or unanswered. If a question doesn't apply enter "N/A."
☐	**Rate Sheet(s)** Please sign and date rate sheets from your quote for the plans sold. Please do not send all proposed plans.
☐	**Current Carrier Billing** Please include the latest invoice available
☐	**Employee Enrollment Forms** Please verify thorough completion of all forms and that your desired effective date is indicated.
☐	**Defend Plans Employer Acknowledgements of Disclosures** Please sign and date this document certifying the employer (Plan Sponsor) has reviewed the implications of self-funding.
☐	**Wage and Tax Report** Most recent filing. Please reconcile this report by indicating which employees are enrolling, ineligible or declining.
☐	**COBRA** **For Current Participants please provide:** Member demographics, copy of COBRA Election Form, Qualifying Event Date, Qualifying Event Reason, Coverage being selected, Premiums paid through date **Will group have have any stand-alone COBRA administration.** ☐ YES ☐ NO If "yes", indicate coverages (dental, vision) and the stand-alone COBRA rates to be used for the new effective date.
☐	**Claims History:** If not provided previously. Please submit, for the past two years if available, medical and pharmacy claims experience and information concerning all claims over $25,000. For groups providing two years of claims experience only, employees may skip medical questions (Section 7 of the Defend Plans Employee Application)
☐	**Additional Information** As requested by the underwriter, if any.

IMPORTANT NOTE:

DO NOT CANCEL CURRENT COVERAGE UNTIL WRITTEN CONFIRMATION OF APPROVAL IS RECEIVED FROM THE DEFEND PLANS UNDERWRITERS.

The Defend Plans

AcuityGroup

New Group Submission Checklist

☐	**Mail Check for First Month Fees (Payable to Accuity Group) to:** ***Billing Department, Accuity Group, 1022 Highland Colony Parkway, Ridgeland, MS 39157*** **Attach Copy of this Check to Employer Application** *Note: Client should **not** include payments for current COBRA participants*

	For Brokers
	When submitting your first Defend Plan case or your first case with this Stop-Loss Carrier, please submit the following:
☐	**W-9 Form**
☐	**Insurgency Benefits Producer Agreement and Exhibits** Available from your general agent or through Sales@ProtectPlan.Info
☐	**Copy of Current E&O Policy**
☐	**For Pan American Life** Producer Application and Agreement Fair Credit Reporting Act Disclosure

Next Steps:

Please submit your client's application and other material to Sales@InsurgencyBenefits.com. Insurgency Benefits, the program underwriter, or the program administrator may contact you for additional information. If approved for coverage, the administrator will provide your group with ID Cards and Plan Documents.

IMPORTANT NOTE:

DO NOT CANCEL CURRENT COVERAGE UNTIL WRITTEN CONFIRMATION OF APPROVAL IS RECEIVED FROM THE DEFEND PLANS UNDERWRITERS.

The Defend Plans

EMPLOYER APPLICATION
Administered by Acuity Group, LLC

Instructions for completing this agreement

- The employer or the employer representative must complete the entire Application form with signature.
- The agent must sign and date this agreement.
- A signed copy of the proposal/quote must accompany this submission.
- A check made payable to "Acuity Group, LLC for the first month's total payment must be sent to Acuity Group with a copy of this check attached to this application.

Requested Effective Date:

_____/_____/_____

1. Company Information

Full Legal Name of Company / Plan Sponsor

Street Address

City | State | Zip

Mailing Address

City | State | Zip

Company Contact

Contact Phone Number | Email Address | Contact Fax Number

Nature of Business | Date Company Established / / | SIC Code

Federal Tax Identification Number

Employer / Business Type (Check one): ☐ Single Employer ☐ Church or Government Agency ☐ Union ☐ Other

Employer contribution percentage is_____% ☐ Employee Only ☐ Employee and Dependents

NOTE: *The employer is required to contribute at least 25% of the monthly premium due for Employee only coverage.*

Are subsidiaries/affiliates to be included? ☐ Yes ☐ No If "Yes", list names and addresses: _____

If subsidiaries/affiliates are included, do you want separate bills sent to each of these subsidiaries I affiliates? ☐ Yes ☐ No

Fiscal Plan Year: The 12-month period upon which the Form 5500 is based on and filed. If you are a small group that does not file a Form 5500, the plan year must still be a 12-month period. Typically, this is the 12-month period beginning either: 1) the date open enrollment elections are effective; or 2) the date you normally make benefit changes.

- Is the group ERISA or NON-ERISA? ☐ ERISA ☐ NON-ERISA
- Profit/Non-Profit: ☐ For Profit ☐ Not for Profit

2. Benefit Information

List most recent/current insurance carrier(s) or TPA(s): _____

Current group health plan: ☐ Fully Insured ☐ Self-Funded ☐ N/A - No Current Coverage

What was/is the original self-funded plan effective date? _____/_____/_____

3. Workers' Compensation Information

Name of Workers' Compensation Carrier

Policy Number | Carrier's Phone Number

4. COBRA Information

Are you subject to COBRA? ☐ Yes ☐ No

NOTE: *You are subject to COBRA if you or your controlled group, as defined in 26 U.S.C. 1563, employed at least 20 full or part-time employees on at least 50% of the typical business days during the previous calendar year. You must include employees residing outside the U.S.*

Will Acuity Group administer COBRA coverage? ☐ Yes ☐ No If no, please provide administrator information:

Name: _____

Address: _____

Phone: _____ Fax: _____

Is anyone in your group 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 of this application may result in a rate adjustment or declination.*

Employee/Dependent	Termination Date of Original Coverage	Qualifying Event

5. Medical Plan Selections

Select Pricing Arrangement: ☐ Standard Network ☐ Risk Based Pricing (RBP)

Employers may select any or all plans:

Secure Co-Pay Plans

☐ 500 Co-Pay
☐ 1000 Co-Pay
☐ 2000 Co-Pay
☐ 3000 Co-Pay
☐ 4000 Co-Pay
☐ 5000 Co-Pay

Secure HSA Plans

☐ HSA 3000
☐ HSA 4000
☐ HSA 5000

6. Employee Information

Total number of full-time employees: | Total number of part-time employees: | Total number of eligible employees:

Total number of enrolling employees: _____

NOTE: *Minimum participation requirement: groups of 50 or fewer eligible employees: 75% of all eligible employees; groups of 51 or more eligible employees: 60% of all eligible employees. Eligible employees are those full-time employees without coverage elsewhere. If Employer contributes 100% of the employee premium, 100% of employees must enroll.*

Minimum hours (per week) required for eligibility: _____

NOTE: *Minimum of 30 hours per week, 48 weeks per year, which may be reduced to 20 hours per week by request.*

6. Employee Information (continued)

Employee probationary period: ☐ 30 days ☐ 60 days

NOTE: *Employee effective date first month after probationary period.*

Employee Classes (define): ☐ Class I ☐ Class II ☐ Class III ☐ Class IV

Any excluded classes of employees? ☐ Yes ☐ No If "Yes", give descriptions and reasons _____

Does current health insurer /TPA extend coverage/benefits for disabilities after termination date? ☐ Yes ☐ No

If "Yes", please provide copy of policy, employee certificate and/or Summary Plan Description (SPD)

IMPORTANT NOTICE: *All eligibility information must be complete and accurate. Excess Loss Coverage may be rescinded, reformed or declined if employer provides false or misleading information.*

7. Special Requests

(Subject to written approval by Acuity Group and Excess Loss Coverage Carrier)

8. Applicant Agreement

The agent has explained the details of the coverage(s)/benefits and I, the undersigned, acknowledge reading the entire application, including the Claims Funding Agreement and Administrative Services Agreement. The answers I have provided are true and complete. I understand that the terms and conditions herein binds the applicant only when the applicant receives written approval.

The Secure Plans are level-funded plans designed to set your company's maximum financial responsibility. however, you may be subject to financial responsibility greater than your final quoted rates under some circumstances. For example, errors by the administrator or by you may result in additional financial exposure. To minimize such exposure, the administrator and employer must manage this plan in accordance with the standard plan documents. The excess-loss carrier has the right to audit claim and eligibility information prior to funding claims filed under the stop-loss policy.

Full Legal Business Name:

Signature:

Name:

Dated on / /

Benefits are not effective until you receive written approval from the program underwriter or administrator. Do not cancel coverage until you receive written notice of approval. Applications will not be underwritten until all required information is submitted. The deposit amount will be returned to you if the Application is denied.

9. Agent / Producer Information

To avoid delays in commission processing, please complete the following section in its entirety.

Writing Agent	Second Writing Agent
Writing Agent:	Second Writing Agent:
Agency:	Agency:
Agency License Number:	Agency License Number:
Commission Payable to: ☐ Broker ☐ Agency	Commission Payable to: ☐ Broker ☐ Agency
Phone:	Phone:
Email:	Email:
Fax:	Fax:
Commission Percentage:	Commission Percentage:

I have notified the employer not to terminate present benefits until notified in writing of acceptance of this application.

Broker Signature:	Broker Signature:
Date:	Date:

10. General Agent Information

General Agency Name:	
General Agency Number:	General Agency License Number:
General Agency Contact:	General Agency Phone:
General Agency Email:	General Agency Fax:

11. Client Contact Information

Please provide the Contact Information for those involved in the administration of your plan.

NOTE: *Only one person may be the Primary contact for each section.*

Contact #1:

Name:	Title:	
Phone:	Fax:	Email:

Primary Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Additional Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

(continued)

Contact #2:

Name:	Title:
Phone:	Fax:	Email:

Primary Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Additional Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Contact #3:

Name:	Title:
Phone:	Fax:	Email:

Primary Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

Additional Contact for: ☐ Implementation ☐ Privacy officer ☐ Executive ☐ Eligibility ☐ Claims
☐ Case Management ☐ HR/Benefit manager ☐ Web portal ☐ Billing ☐ Funding

12. Employer Mandate

What is the total count of full-time employees including full-time equivalent employees? _____

NOTE: *If the answer to this question is LESS THAN 50 FTEs your are NOT required to complete the remainder of this section.*

How are you determining your standard hours for full-time? ☐ 30 hours per week **or** ☐ 130 hours per month?

Are seasonal employees eligible for coverage if they meet the full-time employee status? ☐ Yes ☐ No

What is the employee payroll period? ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Other: _____

Select which methodology is used in determining the hours of service credited.

☐ Measurement Period begins with the first day of the pay period that includes the first day of the Measurement Period and ends with the last day of the last pay period that ends on or before the last day of that Measurement Period.

OR

☐ Measurement Period begins with the first day of the pay period that follows the first day of the Measurement Period and ends with the last day of the last pay period that includes the last day of that Measurement Period.

In determining eligibility for full-time and full-time equivalent employee status,
are you using a measurement period (also referred to as a look-back period)? ☐ Yes ☐ No
If yes, the next 2 questions must be answered

For determining full-time employee status for ongoing employees, the length for all three periods must be defined.

Standard Measurement Period: _____ Standard Stability Period: _____ Administrative Period: _____

For determining full-time employee status for new variable hour, seasonal or part-time employees, the length of all three periods must be defined.

Initial Measurement Period: _____ Initial Stability Period: _____ Administrative Period: _____

The Defend Plans

Employer Acknowledgement of Disclosures

Congratulation on selecting the Defend Plans, a fixed-cost, self-funded program. The Defend Plans may look a lot like traditional, fully insured benefit plans, but there are significant differences of which you need to be aware. This Disclosure form covers many, but not all, of those differences. You should consult with your broker and other advisors to make sure you understand all these differences.

Self-Funding: Important Considerations

In traditional fully-insured plans, an insurance company is responsible for reimbursing all eligible claims. In self-funding arrangements, that responsibility shifts to the plan sponsor, which in the case of the Defend Plans is your company. Your exposure to claims is limited by including Excess Loss coverage (commonly called "Stop-Loss coverage") as part of the program. Which means you should know the following:

- **Your Benefit Plans:** There are several health plans in the Defend Plans program. You, as the Plan Sponsor, may allow your employees to choose one or more of these plans, subject to underwriting guidelines.

- **Your Third Party Administrator**: Administrative functions for the Defend Plans are handled by Acuity Group, LLC (Acuity). As your plan administrator (often referred to as a "third party administrator" or "TPA"), Acuity will, among other services:
    - Maintain proper funds on deposit for claims payment as received from you, the Plan Sponsor
    - Pay claims according to your plan document
    - Provide claim reports and other data to your company as Plan Sponsor and your Excess Loss insurer
    - Provide plan information and assist with filing government-required reports
    - Bill, collect and disperse fees, taxes and Excess Loss insurance premium for your Plan.
    - They do not process ACA fees for which you may be liable

- **Your Plan Document:** Acuity will provide you with a Summary Plan Document explaining plan eligibility, benefits, limitations, exclusions termination provisions and other aspects of your Defend Plans coverage. Acuity will also send you employee benefit descriptions, employee and dependent medical coverage cards and other documents related to the administration of your plans.

- **Your Excess Loss Carrier:** The Defend Plans protects your company against unexpected and excessive claims through stop-loss coverage. These insurance policies limit the amount your company, the Plan Sponsor, pay toward eligible medical claims.
    - **Specific Stop-Loss Coverage** protects your company against unexpected, high-dollar medical and prescription claims on any one individual. Your Defend Plan quote identified the per-person "attachment point" or deductible for this coverage This deductible is the amount you are responsible to pay toward eligible medical claims on behalf any individual member of your company's plan. A minimum amount may be required by law. Eligible claims above this attachment point are reimbursed by your excess loss carrier.

- **Aggregate Stop-Loss Coverage** limits the total eligible medical and prescription expenses that your company will pay for all members of your plan during a Contract Period.
- Plan deductibles, co-pays and other **payments made by covered individuals** do not count towards either the specific or aggregate stop-loss coverage.

- The Defend Plans are a level funded plan designed to set your group's maximum financial responsibility. However, your company can be subject to financial responsibility greater than your final quoted rates under some circumstances. For example, errors by you or the administrator can result in additional financial exposure to you. To minimize exposure, you and the administrator must manage this plan in accordance with the standard plan documents. The stop-loss carrier has the right to audit claim and eligibility information prior to funding claims filed under the stop loss policy.

- **Your Contract Period**: The Defend Plans all feature a 12/18 Contract period. This means that eligible medical claims incurred within the first 12 months of your coverage and paid within 18 months from the start of the Contract Period are covered by the plan or Stop Loss coverage. The plan's total maximum costs for a 12/18 Contract period includes the costs for the six months of run-out claims—claims incurred in the first 12 months of coverage, but not submitted until the 13th month or later. **IMPORTANT NOTE**: Claims incurred during the 12 months of coverage but submitted after the 18th month of the Contract Period are *not* covered by your stop-loss coverage and are the responsibility of the member or you, the Plan Sponsor.

- **Your Fixed-Costs:** Each month you are responsible for paying one-twelfth of the estimated costs plus monthly stop-loss insurance premiums, and various monthly administrative fees. These costs usually vary by the number of covered individuals in your plan during a month. They do not vary by the claims paid in any given month, however. If eligible claims paid out by Acuity exceeds the amount you have paid toward claims, the difference will be advanced to you. Future monthly payments will "pay back" this advance. **IMPORTANT NOTE**: Since Aggregate Excess Loss coverage is determined by your Contract Period, if you terminate coverage prior to the end of your Contract Period you will be responsible for all eligible medical claims that would have been covered by the Aggregate Excess Loss coverage.

Referenced Based Pricing (RBP)

Choosing an RBP arrangement can significantly reduce the cost of coverage without reducing the quality of care. However, these reimbursement arrangements do not include a network for hospitals and other facilities providing services and other treatments to your employees and their dependents nor for certain other services such as durable medical equipment. Balance billing can incur when employee and their dependents access these non-network providers. (Balance billing can also incur when employees and their dependents access out-of-network providers under traditional PPO arrangements).

- The Defend Plans mitigate this risk by providing patient advocacy through ClaimDOC. ClaimDOC works to eliminate or minimize balance billing incidents and amounts. They also help educate patients and providers about RBP reimbursements prior to the claim being incurred.
- While ClaimDOC has a strong track record in reducing and eliminating balance billing issues, there is no guarantee they will be successful in every incident.

The Defend Plans

Self-Funding Advantages and Disadvantages

Self-funding typically offers you, the Plan Sponsor, several **advantages** including:

- No premium tax on the self-funded claim fund
- You may offer the same health plan in multiple states
- You receive any surplus in your claims fund shortly after the end of your Contract Period. With the Defend Plans, you receive 100% of this surplus.

There also present some **disadvantages**, including:

- You, the employer, assume all risk up to the Excess Loss coverage attachment points. Your monthly payments cover this exposure. And with the Defend Plans, if incurred eligible claims exceed the amount you've paid into the claims fund up to that time, and it's within the Contract Period as outlined in your policy, you are advanced the difference
- Employers' assets are exposed to liability created by legal action against the self-funded plan. This risk is reduced by working with reputable administrators and carriers like those available to you through the Defend Plans
- Your company, working through the Defend Plan underwriters and administrators, are providing services normally provided by an insurance carrier. This calls on you to be disciplined when considering exceptions to coverage eligibility or other discretionary payments issues
- As the Plan Sponsor, you may have additional financial liabilities stemming from mistakes made by you or the administrator. For example, if an employee is allowed to join the plan prior to qualifying for coverage, claims paid prior to actual eligibility may be your responsibility.

Fixed-Cost Self-Funded programs with excess loss protection like the Defend Plans are an innovative way for many employers to maximize their employee benefit dollars. Reference Based Pricing arrangements may further reduce costs. Both offer advantages and disadvantages. By signing, below, you certify that you have read and understand the above information and acknowledge that the Defend Plans are part of a self-funded program and is not fully insured coverage. If you have opted for a RBP arrangement, this document also acknowledges your receipt of those disclosures in this document.

_____

Your Company Name

_____ _____

Your Name Your Title or Position

_____ _____

Your Signature Date Signed

The Defend Plans

Group Name: _____

PRIVACY COMMITTEE

Privacy Officer:

Privacy Committee Members:

_____ _____

Signature ***Date***

Please list the name of your Privacy Officer and Privacy Committee Members above. Your Privacy Committee should consist of people you would like to authorize us to release pertinent information to regarding your Plan (i.e. Claims information, Accounting information, etc.)

Please sign and return this form to our office. If any questions, please give me a call at 855-563-9396. Thank you.

Tyler Reeves

AcuityGroup

Provider Nomination Form

Your new **Open-Access Medical Plan** allows you the freedom to choose any provider you wish.

As long as your provider accepts the plan and submits your claim to Acuity Group of Mississippi, LLC, your third-party administrator, you are only responsible for the applicable co-pay, deductible and/or out-of-pocket maximum, as shown on your Explanation of Benefits (EOB).

As part of the ClaimDOC's *Pave the Way*™ program, a ClaimDOC Member Advocate will reach out to your provider to educate them on your new plan and to ensure they have the necessary information to accept your plan.

New Patient: ☐ Established Patient: ☐

Patient Information:

Member Name:		Date of Birth:
Patient Name:		Date of Birth:
Telephone Number:	Email Address:	

Provider Information:

Name of Facility or Practice:		NPI Number:
Name of Doctor:		NPI Number:
Telephone Number:		Appointment Date:
Address:		
City:	State:	Zip Code:

Please submit your completed form to:

Mail: ClaimDOC, LLC.
506 3rd Street, Ste. 200
Des Moines, IA 50309

Fax: (844) 605-7636

Email: membersupport@claim-doc.com

To check the status of your provider nomination, please call 1 (888) 330-7295.

ClaimDOC®
Fair Payment Solutions for Health Plans

The Defend Plans

AcuityGroup

AUTHORIZATION AGREEMENT FOR ACH COLLECTIONS (ACH DEBITS)

I hereby authorize **Acuity Group of Mississippi, LLC** to initiate ACH debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the:

_____ Checking Account

_____ Savings Account

indicated below and the depository institution named below to debit and/or credit the same to such account.

BANK NAME _____

CITY _____ STATE _____ ZIP _____

TRANSIT/ABA _____ ACCOUNT NO. _____

This authority is to remain in full force and effect until **Acuity Group of Mississippi, LLC** has received written notification from me of its termination in such time and in such manner as to afford **Acuity Group of Mississippi, LLC** a reasonable opportunity to act on it.

NAME _____

SIGNATURE _____ DATE _____

NOTE: Please return this signed authorization form along with a copy of a **VOIDED CHECK** (if available) from the above-listed bank account.