WellNet

WellNet Health Broker Guide

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WellNet

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WellNet

WellNet is a nationwide administrator of integrated health plans, population health management (wellness) and risk management programs…all powered by our proprietary technology. Leveraging real-time data, WellNet identifies the root of the problem and provides solutions for immediate cost reduction, sustainable savings and improvements in member health and outcomes.

WellNet Health offers employers with as few as 10 employees fully integrated, self-funded health plans that foster shared accountability between employer and member, delivers transparency of costs and provides the ability to proactively monitor, engage and influence member behavior.

The Control You Need

WellNet gives you access to all plan data and, more importantly, insightful analysis in real-time via our easy-to-use WellNet 4.0 management dashboard. Through intuitive dashboards leveraging real-time data, companies are empowered to manage their health plan's performance.

The Flexibility You Want

Customized plan designs, stop loss protection and funding options combined with fully integrated population health management programs enable us to structure the most appropriate health plan for your company's needs.

Know What You Pay For

Our program offers 100 percent visibility into every cost; enabling companies to budget their healthcare spend. Unlike other health plans, with WellNet, employers only pay for the healthcare their group consumes…no more lining insurance carrier pockets.

New Levels of Customization

WellNet offers a true alternative to the carrier market, providing affordable and innovative self-funded health plans to groups with as few as 10 employees. We provide access to premier national PPO networks, 65,000+ pharmacies, cost containment programs, population health management and white glove member and account services.

With PPO, EPO and HDHP plan designs, it's easy to find a plan that works for your company's specific needs.

Protection You Can Count On

All of WellNet's plans come with both specific and aggregate stop loss protection as well as immediate specific reimbursement and monthly aggregate accommodation. These features limit monthly costs fluctuations to changes in enrollment, not claims utilization. In addition, WellNet clients are provided with a fully integrated suite of technology and health management services delivered by our team of dedicated Account Managers and Registered Nurse Health Coaches.

Group Eligibility

Corporations, partnerships and sole proprietorships where there is a clear employee/employer relationship are eligible for WellNet Health.

Newly Established Companies

Companies that have been in business for three months or less must provide the following to be considered as eligible employer groups:

- Articles of Incorporation and/or Partnership and Proof of Establishment
- Financial Viability Letter from their Financial Institution

Special Consideration Groups/Industries

The following industries and groups may be required to submit additional information to be considered or may be considered ineligible:

Religious Organizations
Metal/Coal Mining
Oil and Gas Exploration/Extraction
Explosives
Asbestos Products
Long Haul Trucking
Tobacco Stores and Stands/Tobacco Products
Commercial Sports
Legal Services
Medical Services

The following industries and types of groups are ineligible:

Multiple Employer Trust (METs)
Multiple Employer Welfare Associations (MEWAs)
Associations
Employee Leasing Firms
Professional Employer Organizations (PEOs)
Human Resource Management Companies
Taft Hartley Trusts

Participation

Employers must meet the following participation requirements:

- At least 50 percent of all full-time employees (FTEs) must participate in the Plan
- At least 75 percent of all eligible employees should have credible coverage
- The employer is required to contribute a minimum of 50% of the employee only cost of the lowest cost plan offered.
- If the employer contributes 100 percent of the employee premium, 100 percent participation is required
- *Exceptions to the above provided upon request*

Employee Eligibility

All full-time employees (working at least 30 hours per week/48 weeks per year) are eligible. Owners, sole proprietors, partners, officers and directors are eligible only if they qualify as full-time employees.

Eligible dependents of an employee are a lawful spouse and/or unmarried children from birth to age 26. A child means a child by birth, legal adoption or legal guardianship or a stepchild. Employers may choose to include domestic partners as eligible dependents. This designation must be made at the beginning of the plan year.

Retirees can be eligible for medical benefits only if the group has 20 or more employees and has received underwriting approval.

Contract laborers and employees paid on commission are eligible for benefits on the employer plan if more than 50 percent of their income is derived from that employer. Tax information is required as proof of eligibility. A group cannot be solely comprised of 1099 employees.

Pre-existing Condition Limitation

NOTE – pre-existing condition limitations will NOT apply to Plans with effective dates of January 1, 2014 or later

A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received during six months before the enrollment date under the group insurance plan. When a person enrolls on a timely* basis, coverage is provided for pre-existing conditions after the person has been covered by the group plan for 12 consecutive months. When a person does not enroll on a timely basis, other provisions apply. If the person has prior creditable coverage, the pre-existing time period may be shortened or waived as outlined in the Summary Plan Design (SPD).

Prior credible coverage includes: other group health insurance plans, Medicare, Medicaid, TRICARE, or other military-sponsored health care, and similar types of plans.

A pregnancy is not subject to a pre-existing condition limitation. A newborn or adopted child is not subject to a pre-existing condition limitation if we receive an enrollment form for the child within 31 days from the date of birth, adoption or placement for adoption.

* *Timely enrollment occurs within 31 days, or as allowed under the Plan, from the date a person is eligible for coverage.*

Standard Stop Loss Provisions

- 12/18 contract on specific and aggregate stop loss insurance
  - Contract covers a 12-month plan year plus a six month run-out period
  - Specific stop loss deductibles of $10,000+ (*minimum varies by state)*
- Immediate specific reimbursement
- Monthly aggregate accommodation
- Groups with 50+ enrolled employees can fund to “Total Estimated Expected Cost” versus “Total Estimated Maximum Cost”
- Other options available upon request

WellNet

Quote Requirements

Please submit all quote requests to quotes@wellnet.com.

Include all required information to ensure that your request is processed without delay.

Availability By State

WellNet Health is available in all 50 states and the District of Columbia (DC) for plans with a minimum of 10 enrolled employees.

A minimum of 51+ full-time equivalents (FTEs) is required for employer health plans in North Carolina (NC) and New York (NY).

A minimum of 15+ FTEs is required for group health plans in Delaware (DE).

Employer health plans with 50 or fewer FTEs in Alaska (AL), Arkansas (AK), Colorado (CO), Connecticut (CT), Florida (FL), Kansas (KS), Louisiana (LA), Maine (ME), Maryland (MD), Minnesota (MN), Nevada (NV), New Hampshire (NH), North Dakota (ND), Oklahoma (OK), Oregon (OR), Pennsylvania (PA), Tennessee (TN) and Vermont (VT) have additional specific deductible and/or aggregate attachment point restrictions.

All Quotes

Employer Information

- Company name
- SIC code
- Effective date
- Address for main office; zip codes for all other locations
- Current benefit summary or plan design
- Desired plan design(s)
- *Current and renewal rates (if available)*

Employee Information (census in .xls file format)

- Date of birth
- Gender
- Home zip code
- Work location *(if there is more than one)*
- Coverage tier (waived, employee, employee + spouse, etc.) for all employees including those on COBRA and in the waiting period

Plan Designs

WellNet offers standard PPO, EPO, and QHDHP plan designs. In addition, we have the ability to match in-force plan designs for existing self-funded clients or those clients with 100+ enrolled employees.

Fixed Costs

Specific & Aggregate Stop Loss

Insurance premiums for specific and aggregate stop loss insurance.

PPO Services

Fee for PPO network access.

TPA Fees

Fee for third party administration services. Includes access to PBM (CVS Caremark), large case management (LCM), utilization review (UR), COBRA administration and any implementation and/or run-out fees commiserate with the terms of the stop loss contract.

Program Expense

Comprised of broker's commission (6 percent of Estimated Maximum Cost unless adjustment is requested) and WellNet's revenue, which covers the cost of underwriting, a dedicated Account Manager, live member services representatives, WellNet 4.0 technology, Care Management (Registered Nurse Health Coaches), and other ancillary services.

Insurance regulation has traditionally been a state responsibility, which makes for tremendous variety among all 50 states. For example, all states require insurance carriers to offer or include coverage for specified healthcare services; these requirements are known as state benefit mandates. Even if multiple states have mandates concerning the same type of benefit, they may vary in scope or specificity. Fully insured plans are subject to these state mandates, Self-insured plans are not subject to state regulation, only federal regulation.

ERISA and HIPAA

Regardless of whether health plans are fully insured or self-funded, at a minimum they are subject to federal standards, fully insured plans are further regulated by state insurance regulations. Two federal laws, the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), have significant impact on how health coverage is provided.

ERISA outlines minimum federal standards for private-sector, employer-sponsored benefits, including health benefits. In general, ERISA requires that plan fiduciaries act prudently and in the best interest of beneficiaries, participants be informed of their rights and there be disclosure of a plan's financial activities.

While ERISA provides for general regulation of employee benefit plans, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically regulates health benefits. HIPAA established federal requirements on private coverage and issuers of such coverage, including the availability and renewability of coverage for certain individuals under specified circumstances, limitations on the amount of time that coverage for pre-existing medical conditions may be excluded and prohibition of discrimination on the basis of health factors. HIPAA also includes provisions addressing the electronic transmission of health information and the privacy of personally identifiable medical information.

FOR ADDITIONAL INFORMATION ON ERISA & HIPAA please visit: http://www.dol.gov/ebsa/compliance_assistance.html

Stop Loss Insurance

Although self-funded health plans are not subject to state regulations, stop loss insurance policies are subject to state insurance regulators. Depending on the state the corporation is domiciled in, there may be certain restrictions on group size, specific and aggregate deductible levels or other limitations. If you are unsure about the restrictions for a particular state, please contact us for more information.

WellNet works with several stop loss carriers. All of our stop loss carrier partners are A- rated or better and offer stop loss contract terms in-line with the Standard Stop Loss Provisions described under “”Quote Requirements” above. WellNet underwrites one of three ways:

Individual Health Questionnaires

All eligible employees, including COBRA participants and new employees in the waiting period, must complete individual health questionnaires. Eligible employees who are waiving coverage are not required to provide medical information. Individual health questionnaires must be signed by employees within sixty (60) days of the Plan’s proposed effective date.

WellNet accepts individual health questionnaires via:

- Paper/.pdf applications – available from WellNet upon request
- On-line through WellNet 4.0
    - WellNet supplies a secure link and instructions at no additional charge
    - Questionnaires are collected by WellNet and then distributed back to broker when complete
    - Groups can use paper/.pdf applications alongside
- FormFire or EasyAppsOnline – broker paid services

Paid Claims

WellNet will accept any historic paid claims data to assist in underwriting. Our preference, when underwriting based on paid claims, is to review the following within sixty (60) days of the Plan’s proposed effective date:

- Monthly paid claims and corresponding enrollment for 24 consecutive months
- Large claims reports for 24 consecutive months, preferably including diagnosis and prognosis
- Benefit summary or plan design for current and prior year
- *Specific and aggregate stop loss premiums (self-funded groups only)*

Employer Group Disclosure

Depending on a group’s demographics, WellNet can underwrite solely based on a Group Disclosure form in the absence of individual health questionnaires or historic paid claims.

Employer Requirements

All Employers must submit the following documents in order to complete underwriting:

- Employer application*
- Employer certification*
- Employer disclosure *
- Electronic eligibility file (.xls file format)*
- Most recent quarterly wage & tax reports
- Most recent invoice from current carrier
- The final rate sheet for each plan that the employer would like to offer must be signed and dated.

Broker Requirements

Brokers who are not appointed with the stop loss carrier must submit an Agent Data Sheet* along with copies of their insurance license and Errors & Omissions (E&O) insurance policy. This form only needs to be completed once. WellNet will pay any appointment fees.

Rate Changes

Rates cannot change during the plan year unless:

- Enrollment changes by more than 20 percent
- Subsequent information becomes known which, if known prior to the effective date, would have affected the rates, deductibles, terms or conditions for coverage.

** Call or email us at 888-947-9478 or quotes@wellnet.com to request a copy.*

Required Employer/Broker Materials

The following items are required to begin the implementation process.

- All of the Employer and Broker Requirements described in "Underwriting Guidelines"
- A binder check made out to *WellNet Healthcare Administrators Inc.* in the amount of the monthly Estimated Maximum Cost (or Estimated Expected Cost if approved by WellNet) indicated on the rate sheet.

  If mailing the check by UPS or FedEx send to:
  WellNet Healthcare Administrators Inc.
  Attn: Finance Department
  57 Street Road
  Suite O
  Southampton, PA 18966

  If mailing the check by USPS send to:
  WellNet Healthcare Administrators Inc.
  Attn: Finance Department
  PO Box 354
  Southampton, PA 18966

  Email a digital copy of the binder check to **quotes@wellnet.com**

Onboarding Materials

Employers will receive onboarding materials including the following. These documents are also available online via WellNet 4.0.

- Welcome Letter
- Summary of Benefits and Coverage (SBC)
- Contact List
- Temporary ID Card
- Instructions on How to Locate a Network Provider
- Instructions on How to Log Into 4.0 Web Portal

Plan Documents

Employers must review and sign the following documents. WellNet provides countersigned copies of these documents. Employers should retain copies of all signed documents for their records.

- Administrative Services Agreement – allows WellNet to administer the health plan on behalf of the employer.
- Plan Document and Summary Plan Description – governs the administration of the health plan; includes a benefit summary, lists of covered, excluded and limited services, etc.
- Stop Loss Application – initiates the specific and aggregate stop loss insurance policies.
- New York Goods Pool – must be on file in the event that a member requires services in New York.
- Network/Utilization Review Agreement (if applicable) – agreement with the network or utilization review provider.

Employee Enrollment Form and Questionnaire

Employer Application

Individual Medical Questionnaire

WellNet

Employer Name _____

Employee Information

Last Name: _____ **First Name:** _____ **MI:** _____ **Suffix:** _____

Address Line: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____ **Phone:** _____-_____-_____

Employment Status:
- O Full Time, full time hire date: _____/_____/_____
- O Part Time, hours worked per week: _____
- O Independent Contractor

Marital Status:
- O Single
- O Married
- O Divorced
- O Widowed

Employee Election

Do you intend to Enroll or Waive: O **ENROLL** *(continue questionnaire)* O **WAIVE** *(skip to the last page, leave following sections blank)*

If enrolling, who do you intend to enroll?

Spouse:	**Dependent(s):**	**Domestic Partner*:**
O Yes	O Yes	O Yes
O No	O No	O No
O N/A	O N/A	O N/A

Other Insurance Information

Do you or your dependents intend to keep other insurance coverage in addition to the one for which you are now applying? O Yes O No

If yes, list family members who will be covered: _____

If yes, provide insurance company name(s) and policy number(s): _____

For any family members covered by Medicare, provide names and their effective date(s): _____

COBRA Information

Are you currently covered under COBRA or currently in the COBRA election period? O Yes O No

Date of termination: _____/_____/_____ Number of months eligible: _____ Most recent month paid: _____

Applicant Enrollment Information

The table should contain ALL family members applying for coverage.

	Last Name	First Name	MI	Gender	DoB	Height	Weight	SSN
Employee								
Spouse								
Child								
Child								
Child								
Child								
Domestic Partner *								

**Domestic Partner coverage varies by plan*

Failure to provide complete responses may result in a request for additional information and/or an inability to process your enrollment in the benefit plan.

Individual Medical Questionnaire

WellNet

Required Medical Information

1. Are you or any eligible dependent scheduled for or awaiting results of any tests, biopsies, procedures or lab work; or been advised to have a test?
   O Yes O No If yes, explain: _____
2. Have you or any eligible dependent been advised of a condition that will require attention in the next 24 months?
   O Yes O No If yes, explain: _____
3. Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier?
   O Yes O No If yes, explain: _____
4. Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care for any condition/surgery/procedure?
   O Yes O No If yes, explain: _____
5. Are you or any eligible dependent disabled?
   O Yes O No If yes, explain: _____
6. Are you or any eligible dependent hospital confined?
   O Yes O No If yes, explain: _____
7. Have you or any eligible dependent used tobacco products in the past twelve (12) months?
   O Yes O No
8. Are you or any eligible dependent pregnant?
   O Yes O No
   a. Name of pregnant person(s): _____; Due date(s): _____/_____/_____
   b. Expecting a multiple birth?
      O Yes O No
   c. Any history of fertility treatment?
      O Yes O No If yes, elaborate: _____
   d. Are there any known complications?
      O Yes O No If yes, elaborate: _____
   e. Is a C-Section planned?
      O Yes O No If yes, elaborate: _____
   f. Is the individual getting regular prenatal care?
      O Yes O No If yes, elaborate: _____
   g. Has the individual been tested for Group B Strep (not strep throat)?
      O Yes O No If yes, results: _____
   h. Has the individual had prior pregnancies?
      O Yes O No How many: _____
      i. Delivery by: O C-Section OR O Vaginal delivery
      ii. Has the individual had any multiple births?
         O Yes O No If yes, explain: _____
      iii. Any issues with prior pregnancies?
         O Yes O No If yes, explain: _____
      iv. Has the individual had any prior pregnancies end in fetal demise?
         O Yes O No If yes, explain: _____
   i. Does the individual smoke currently?
      O Yes O No
   j. Has the individual smoked in the past?
      O Yes O No If yes, when did the individual quit smoking? _____

Failure to provide complete responses may result in a request for additional information and/or an inability to process your enrollment in the benefit plan.

Individual Medical Questionnaire

Required Medical Information (continued)

9. In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for any of the following conditions:

Condition	Yes	No	Enrollee Name(s)	Treating Physician(s)	Diagnosis Date	Medication / Treatment / Surgery
AIDS/HIV/AIDS Related Complex						
Arthritis/Back/Joint Disorder						
Birth Defects/Congenital Disorder						
Breast Cancer						
Cancer/Tumor						
Diabetes						
Drug/Alcohol Abuse						
Heart/Blood/Vascular/ Hypertension						
Immune System Disorder						
Infertility						
Kidney Disorder						
Liver Disorder/Hepatitis						
Mental Disorder						
Neurological Disorder						
Organ/Tissue Transplants						
Respiratory/Lung Disorder						
Stroke						
Systemic Lupus/Multiple Sclerosis						

Failure to provide complete responses may result in a request for additional information and/or an inability to process your enrollment in the benefit plan.

Individual Medical Questionnaire

WellNet

If Enrolling: Authorization to Release Medical Information for Enrollment

I hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this application and for the ultimate determination of eligibility for benefits under the Plan. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Employee Signature: _____ Date: _____

If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of employee: _____

If Waiving: Reason for Waiving Coverage

O Other group/individual plan O Medicare O Medicaid O No Coverage O Other *(explain below)*

If other, explain: _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage or excluded from coverage for a period of time as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents.

All Employees: Employee Agreement

I affirm that I have reviewed all responses provided within this form about me and my dependents. Furthermore, I attest that they are true and correct to the best of my knowledge and that no material information has been withheld or omitted.

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

I understand that information on this application is valid for a maximum of 90 days from the date of signature. To be a valid enrollment, your signature and date are required

Employee Signature: _____ Date: _____

If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of employee: _____

Failure to provide complete responses may result in a request for additional information and/or an inability to process your enrollment in the benefit plan.

Employer Application

1. Full Legal Business Name of Plan Sponsor _____

2. Street Address _____ City _____ State _____ ZIP _____

3. Mailing Address (if different) _____ City _____ State _____ ZIP _____

   County _____ Phone No. _____ Fax No. _____

4. Nature of Business _____ SIC Code _____ Date Business Started _____ Federal Tax ID No. _____

5. Contact name at Employer _____ Preferred contact method (phone / fax / e-mail): _____

6. If subsidiaries/affiliates are included, do you want separate bills sent to each of these subsidiaries/affiliates? ○ Yes ○ No (Add Subsidiary billing info on pg. 3)

7. Is this group a Union? ○ Yes ○ No
   If so, what is the Name of the Union _____ If so, what is the Local Number _____ What is the Local Location _____
   Is the PLAN subject to collective bargaining? ○ Yes ○ No Exp. date: _____

8. Is this a Government Plan: ○ Yes ○ No
   If so, is HIPAA applicable ○ Yes ○ No Does the Plan comply with any state mandated benefits ○ Yes ○ No
   List all states in which the Plan has Participants _____

9. Is this a Church Plan ○ Yes ○ No
   If so, is HIPAA applicable: ○ Yes ○ No Does the Plan comply with any state mandated benefits: ○ Yes ○ No
   List all states in which the Plan has Participants _____

10. Name of person for service of legal process _____

11. Employer contribution percentage is _____%. The employer is required to contribute a minimum of 50% of the employee only cost of the lowest cost plan offered.

12. List prior insurance carrier(s) or TPA(s) during previous two (2) years:

_____

Medical Current group health plan (check one) ○ Fully Insured ○ Self-Funded ○ N/A

13. Name of workers' compensation carrier _____

14. Are you subject to COBRA? (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 business days during the previous calendar year. (Includes employees residing outside the U.S.) ○ Yes ○ No

15. 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).

	Termination Date of Original Coverage	Qualifying Event

16. Would you like WellNet to provide COBRA administration services for your group? ○ Yes ○ No

If not, who will be providing COBRA administration services? (Include Address, Phone, and Fax)

Address _____

Phone _____ Fax _____

Employer Application

WellNet

Employee Data

1. Total number of full-time active employees _____

2. Minimum hours (per week) required for eligibility _____
   Minimum of 30 hours per week, 48 weeks per year, which may be reduced to 20 hours per week by request.

3. Total number of eligible employees _____

4. Total number of enrolling employees _____
   Minimum participation requirement is 75% of all eligible employees (but not less than 50% of all full-time employees)

5. Employee Classes (Give descriptions, if applicable): Class I _____ Class II _____

   Class III _____ Class IV _____

6. Are you establishing a retiree class for medical? ○ Yes ○ No If yes, attained age _____ Years of Service _____

7. Any excluded classes of employees? ○ Yes ○ No If yes, give descriptions and reasons: _____

8. Employee probationary period ○ 30 days ○ 60 days ○ 90 days ○ Other (Minimum of 30 days; Maximum of 90 days)

9. Employee effective date ○ Immediate after probationary period ○ First of month after probationary period

10. Employee termination date ○ Immediate ○ End of month

11. 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.

12. Does your group wish to extend coverage/benefits to domestic partners of eligible employees? ○ Yes ○ No

13. How many of your employees do not speak English? _____ Language(s) spoken _____

14. If your group is offering an HSA or HRA plan, who will be providing HSA/HRA administration services? _____

Plan Selections

PLAN Option 1	PLAN Option 2	PLAN Option 3	PLAN Option 4
Plan Name (as seen on proposal)	Plan Name (as seen on proposal)	Plan Name (as seen on proposal)	Plan Name (as seen on proposal)
Network(s):	Network(s):	Network(s):	Network(s):

15. Where should member ID cards be sent? ○ Employee Home Address ○ Comapany HQ

Employer Application

Termination of Employment When Employee Services End

The Employer terminates employment after an employee has not worked for the Employer for _____ work days (e.g. 3, 5, 10 working days). If labor laws such as FMLA or any other terms, conditions or contract of employment require that the Employer continues to employ an employee for a longer period of time, the Employer will give written notice to the TPA when the Employer terminates employment for that employee.

If your enrollment decreases, you will continue to be responsible for 80% of the monthly Maximum medical claim liability determined for the first month of the plan year. This is referred to as the minimum aggregate attachment point.

IMPORTANT: If you do not remit funds as required after notification by the TPA, administration of your Plan will be terminated. The Employee Retirement Income Security Act (ERISA) places a fiduciary responsibility on the employer, as Plan Sponsor, to ensure the Plan is adequately funded. The TPA may notify all Plan Participants, at your expense, if your claims account is determined to be in jeopardy.

Billing

Payment is due to WellNet by the 1st of the month to avoid cancellation of stop-loss contract.

Name of person for billing questions _____

Phone No. _____ Fax No. _____ E-mail _____

WellNet accepts the following forms of payment. Please select the Employer's preferred method:

○ Electronic Funds Transfer (EFT) ○ Automatic Clearing House (ACH) ○ Check

EFT and ACH payments can be initiated by the Employer or WellNet. If the Employer selects EFT or ACH payment, a member of WellNet's finance team will reach out with additional information.

Checks should be sent to:
WellNet
57 Street Road
Suite O
Southampton, PA 18966
Attn: Finance

Please provide address, phone, and tax IDs for each subsidiary: (if applicable)

Division 1	Division 2	Division 3	Division 4
Name _____	Name _____	Name _____	Name _____
Address _____	Address _____	Address _____	Address _____
Phone _____	Phone _____	Phone _____	Phone _____
Tax ID _____	Tax ID _____	Tax ID _____	Tax ID _____

Division 5	Division 6	Division 7	Division 8
Name _____	Name _____	Name _____	Name _____
Address _____	Address _____	Address _____	Address _____
Phone _____	Phone _____	Phone _____	Phone _____
Tax ID _____	Tax ID _____	Tax ID _____	Tax ID _____

Employer Application

HIPAA Privacy

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the Personal Health Information (PHI) to be disclosed.

Name/Company/Title	Name/Company/Title
Name/Company/Title	Name/Company/Title
Name/Company/Title	Name/Company/Title
Name/Company/Title	Name/Company/Title

Effective Date / Deposit

Deposit must include the first month's fixed costs, plan set up fees, and the first month's maximum claims costs.

Requested effective date _____ Deposit with Application $ _____

IMPORTANT: Benefits are not effective until the undersigned receives written approval. No action is taken on the Application until after all required information is submitted. The deposit amount will be returned to the Applicant if the Application is declined.

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 Plan Supervisor & Benefit Representative Agreement. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the applicant and the TPA only when the applicant receives written approval.

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

Full Legal Business Name _____

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

Print Signature and Title _____

Employer Application

Agent Information

Writing Agent Name _____

Social Security / Identification Number _____

Street _____

City _____ State _____ Zip _____

Telephone Number _____

Fax Number _____

Production Split _____ %

Writing Agent Name _____

Social Security / Identification Number _____

Street _____

City _____ State _____ Zip _____

Telephone Number _____

Fax Number _____

Production Split _____ %

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

Agent Signature X _____ Date _____

Agent Signature X _____ Date _____

Special Request/Comments/Additional Instructions

(Subject to written approval by the TPA)

_____

_____

Internal Use Only

Effective date _____ Approved by _____ Date _____

Comments: _____

Print Application