Premier Senior Health Plan

GROUP APPLICATION

CLIENT INFORMATION

Legal Group Name:		Group Tax ID:	
Current address:			
City:	State:	ZIP Code:	Phone:
Contact Person:	Email Address:		

ELIGIBILITY AND UNDERWRITING REQUIREMENTS

Is the current plan fully insured or self-funded?	Number of retirees/spouses:
Are all retirees/spouses over 65 (Y/N)?	Have all retirees been given "retiree status" with employer (Y/N)?
Are all retirees/spouses currently enrolled in Medicare parts A and B (Y/N)?	

PRODUCER INFORMATION

Producer Name:		Producer Agency:	
Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

PLAN INFORMATION

<u>Medical Plan Deductible</u>: *(One Deductible and one Copay option per group)*
Medical Plans are available to groups with one or more enrollees

☐ $0 ☐ $100 ☐ $500 ☐ $1000 ☐ $1500
☐ No Office Visit or Emergency Room Copay
☐ With $10 Office Visit and $50 Emergency Room Copay

Billing type (list, direct, split):	Number of Full time Employees:	Number of Part time Employees:
Effective Date:	Employer Contribution:	

I attest that all of the above information is accurate and represents the characteristics of this group.

Broker signature:	Date:
Print Name:	Title:
Client signature:	Date:
Print Name:	Title:

PARTICIPATION AGREEMENT
(Rev. 5.15.15)

TO: Trustee of the National Retiree Insurance Solutions Trust (NRIST)
Zions First National Bank. (Pittsburgh, PA), as Successor Trustee, effective May 1, 2015

The Undersigned Employer hereby requests that it be approved as a Participating Employer under The National Retiree Insurance Solutions Trust. The undersigned Employer wants to make certain group insurance coverage under the group insurance policies issued to the Trust is available to its employees or former employees and the spouses of employees or former employees who may be eligible to apply for said coverage.

The undersigned Employer represents that:

1. It has established or is establishing and will maintain an employee welfare benefit plan which includes certain accident and health benefits.

2. The purpose of its participation in this Trust is to obtain the insurance coverage available under policies issued to the Trust in order to continue to provide access for its retirees to certain benefits provided under the policies. The Employer agrees to provide the Administrator with sixty (60) days written notice of its intent to discontinue its participation in the Trust.

3. Unless otherwise provided in plan documents, the benefits available under said plan are identical to and subject to the same terms and conditions as those provided under policies issued to the Trust and applicable to the undersigned Employer.

4. In those cases where it does not pay the entire premium for insurance coverage available through its participation in this Trust, it will endorse the group insurance coverage available to its employees or former employees and spouses of employees or former employees through the Trust.

The undersigned Employer understands and agrees that in no event will the Trustee or administrator of The National Retiree Insurance Solutions Trust be a Plan Administrator or other Fiduciary as to a Participating Employer's employee welfare benefit plan.

The undersigned Employer agrees: (1) that the terms and conditions of said Trust Agreement and any amendments thereto shall be controlling as respects plan administration; and (2) that the terms and conditions of any insurance policies issued to the Trustee covering certain employees or former employees or spouses of employees or former employees of the Employer shall be controlling as respects plan benefits and rates.

The undersigned Employer hereby designates TPG Group, Inc. of Norwalk, Connecticut, as Agent of Record as to the group insurance coverage issued in connection with this Participation Agreement.

The undersigned Employer agrees to allow its present administrator (or other designee) to furnish any information reasonably required by the Settlor, Trustee or Insurer under said Trust in connection with the administration of the Insurance Fund under said Trust including eligibility data.

The undersigned Employer understands that the effective date of any insurance coverage will depend on the term of the policies issued or to be issued to the Trust, and that each eligible individual must apply to and be approved for coverage by the Insurer under said policies. The Employer understands that said group insurance policies issued to the Trust may be amended or cancelled by the Insurer. The Employer further understands that the Settlor may terminate said Trust, and that participation of a Participating Employer and coverage of its Insured Persons may be terminated by the Insurer if the Participating Employer fails to comply with the terms of the Trust, Policies or proposal.

By: Participating Employer – _____

By: _____

_____
Date

Title: _____
Duly Authorized Officer

The above named Employer is approved as a Participating Employer in The National Retiree Insurance Solutions Trust.

For: National Retiree Insurance Solutions Trust
BENISTAR Admin Services, Inc. (Administrator)

By: _____
Donna Wayne

_____
Date

Title: Assistant Secretary

UNITED AMERICAN INSURANCE COMPANY
APPLICATION

Administrative Offices: P.O. Box 8080, McKinney, TX 75070

1. a. Group Policy Number: _____

   b. Policyholder: **National Retiree Insurance Trust**

   c. Enrolling Group: _____

2. Group Requested Effective Date: _____

3. Eligible Member of the Group: **Retirees Age 65 and Older Enrolled in Medicare A & B**

4. Eligible Dependents: **Spouses Age 65 and Older Enrolled in Medicare A & B**

The Applicant hereby applies for Group Insurance and understands and agrees that insurance applied for shall not become effective until the application for Group Insurance is approved by United American Insurance Company at its Administrative Office.

This application, as it may be amended, will become a part of the Group Policy.

FOR THE ENROLLING GROUP:

Signed by: _____ **Title:** _____

Signature: _____ **Date:** _____

Signed at: _____

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