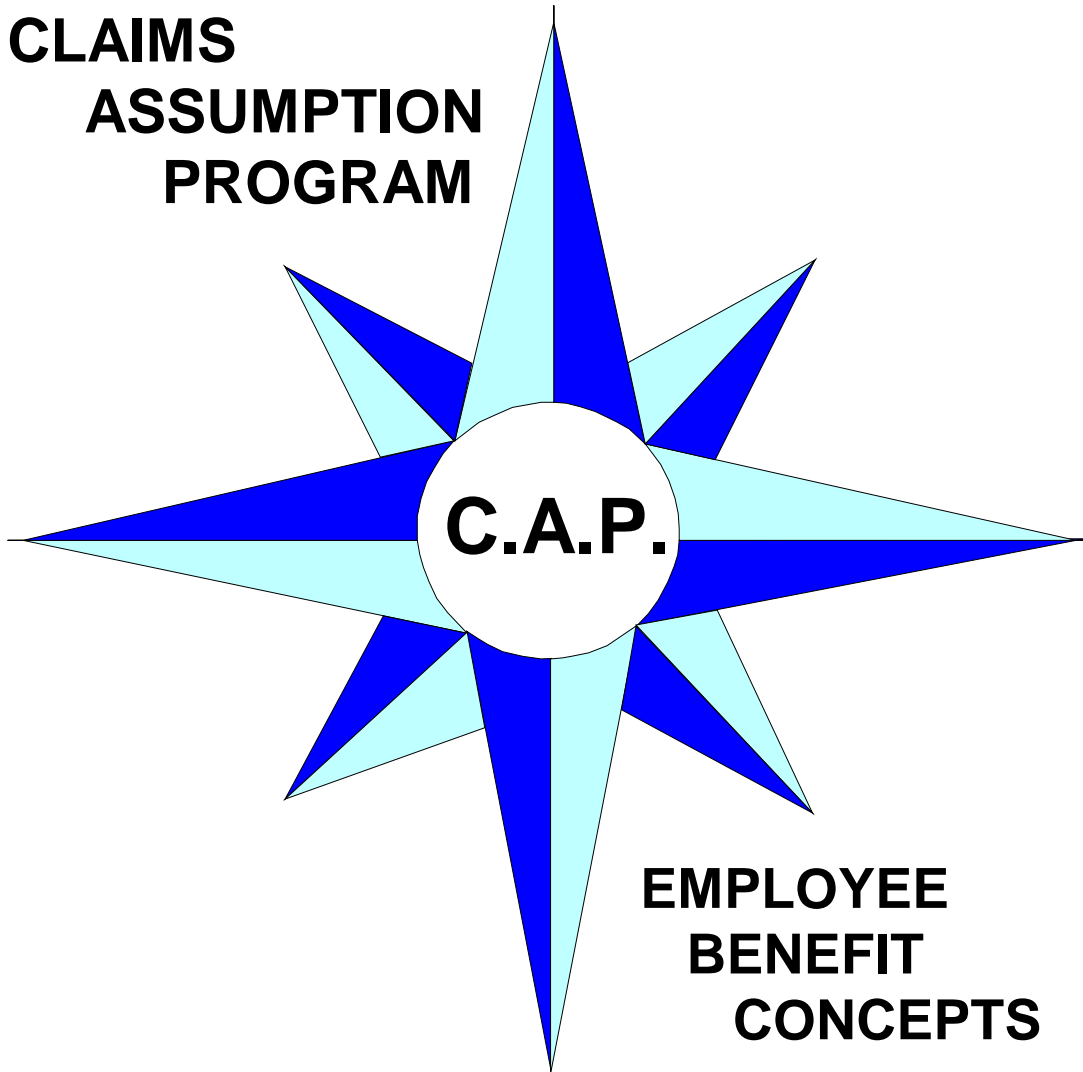


**CLAIMS
ASSUMPTION
PROGRAM**



**EMPLOYEE
BENEFIT
CONCEPTS**

ADMINISTRATION KIT

CLAIMS ASSUMPTION PROGRAM

ADMINISTRATION KIT

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**CLAIMS ASSUMPTION PROGRAM
ADMINISTRATIVE SERVICE AGREEMENT**

MEDICAL REIMBURSEMENT PLAN

This agreement between **Employee Benefit Concepts, Inc.**; herein called the **Administrator and** _____; herein called the **Employer**, shall be effective on the same date as the group health insurance contract or on _____ and is for the purpose of establishing the terms and conditions under which the **Administrator** agrees to provide certain administrative services with respect to the **MEDICAL REIMBURSEMENT PLAN**; herein called the **PLAN**.

CLAIMS ADMINISTRATION: In consideration of the payment of fees described in the attached addendum **Schedule of Fees**, the **Administrator** agrees to perform the following services:

Receive provider bills, claims, and other pertinent information regarding claims from employees, dependents and providers;

Record such information and forward it to the group health insurance company for processing, where appropriate;

Receive the insurance company's *Explanation of Benefits* of adjudicated claims:

Check the accuracy of processed claims against the insured plan and work with the insurance company to resolve any discrepancies;

Process the claim in accordance with the terms of the **PLAN** and determine the **Employer's** liability;

For each claim, produce an *Explanation of Benefits* for the employee and an *Explanation of Disbursements* for the **Employer** with appropriate information for the **Employer** to issue checks for benefit payments;

Optional Service: if elected, produce benefit payment check to be drawn on the **Employer's** account and signed by the **Employer**; distribute such checks to the appropriate recipient; (*see schedule of fees*)

Submit detailed claims reports to the **Employer** on at least an annual basis;

EMPLOYER RESPONSIBILITIES:

Funding for Claims under the Plan: The **Employer** shall be responsible for funding of benefit payments under the *Medical Reimbursement Plan* and shall authorize and sign all checks for such payments. The **Administrator** shall not have access to funds used for benefit payments.

Employee and Dependent additions and deletions from the health insurance plan : the **Employer** shall submit on a timely basis to the **Administrator** written authorization for the addition or deletion of an employee or a dependent, including newborn or adopted children, The **Employer** shall hold the **Administrator** harmless for any consequence resulting from the **Employer's** failure to properly discharge this responsibility.

ERISA: The **Employer** shall serve as PLAN SPONSOR, PLAN ADMINISTRATOR, and CLAIM FIDUCIARY, as these terms are defined in the Employee Retirement Income Security Act of 1974 as amended from time to time.

Taxes and Reports: The **Employer** shall remain responsible for the proper filing, withholding, reporting, and payment of all applicable taxes and reports, including IRS 1099 and 5500 reports.

Expenses: The **Employer** shall be responsible for all expenses incident to the Plan except as specifically assumed by the **Administrator** in this agreement. The **Employer** shall indemnify the **Administrator** and hold it harmless against all losses, damages, and expenses, including attorney fees, occasioned by claims, demands, or lawsuits brought against **Administrator** to recover benefits under the Plan, unless such actions arise out of the negligence of the **Administrator**.

ADMINISTRATIVE SERVICE AGREEMENT (continued)

GENERAL AGREEMENT: The *Employer* and the *Administrator* hereby agree that :

The *Administrator* makes no representations to the *Employer* concerning either federal, state or local tax status of the *Plan*. All such questions should be referred to the *Employer's* legal counsel or tax accountant.

Since the *Plan* is an adjunct to a fully insured plan, it will be subject to the insurance laws and rules of the state of Ohio.

All physical records compiled by the *Administrator* to facilitate the performance of its duties are the property of the *Administrator*.

The Plan: The Medical Reimbursement Plan will be administered in accordance with the written plan description and benefits worksheets attached to this agreement. Any subsequent changes to this plan must be submitted in writing by the *Employer*.

TERMINATION: This agreement shall terminate under any of the following conditions:

1. Termination of the insured plan contract, unless continued by mutual agreement
2. Upon thirty (30) days written notice by either party
3. For failure of the *Employer* to pay agreed upon month fees

Upon termination, in the absence of a **Claims Run-Off Service** agreement, the *Administrator* will process only those claims for which complete information necessary to process the claim was received prior to the date of termination. Claims for which necessary information has not been received and claims received after the termination date will not be processed. Material will be returned to the appropriate party. The Claims Run-Off Service agreement is available at the time of termination and is subject to a separate fee schedule.

Agreed this date _____ at _____

for the Employer

for Employee Benefit Concepts, Inc.

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**CLAIMS ASSUMPTION PROGRAM
ADMINISTRATIVE SERVICE AGREEMENT
ADDENDUM
MEDICAL REIMBURSEMENT PLAN DESCRIPTION**

EMPLOYER NAME _____

INSURANCE CARRIER _____

Effective Date _____

Pursuant to the attached Administrative Agreement a **MEDICAL REIMBURSEMENT PLAN** has been established to provide benefits in addition to the insured plan. The above named insurance company's schedule of benefits, policy provisions and limits, and contract provisions will prevail. Exceptions to the insured plan are defined in the attached **BENEFITS WORKSHEETS**, which describe the Medical Reimbursement Plan. Differences in benefit levels or limits between the insurance company plan and the "employee plan" will be funded by the *Employer*. For this reason the *Employer's* signature is required on the **Benefits Worksheet**.

Other types of benefits such as Dental, Vision, or Disability, etc. may be included in the Medical Reimbursement Plan and funded in part or in whole by the *Employer*. If applicable, the descriptions of these benefits are found on the attached sheets included with this document. [Applies]

The **Medical Reimbursement Plan** applies to all employees and their dependents who are covered under the *Employer's* group health plan, unless specified herein : _____

I have been advised to make the Medical Reimbursement Plan a part of our company's Corporate minutes.

Agreed this date _____ at _____

for the Employer

for Employee Benefit Concepts, Inc.

I have reviewed the *Employer's* current schedule of benefits and policy provisions and those of the new insured plan and have made the *Employer* aware of any significant differences.

Agent of Record

Date _____

MEDICAL REIMBURSEMENT PLAN - BENEFITS WORKSHEET - Page 1

Group Name _____ Broker _____ Effective Date _____

SAAO = Same as Any Other - Deductible and co-insurance applies, "in-Net" or "out of net" values as appropriate

BENEFIT	Prior Ins. Plan _____		New Ins. Plan _____		CAP PLAN	
	In-Network	Out-Of-Net	In-Network	Out-Of-Net	In-Network	Out-Of-Net
Deductible: Single / Family Agg./Spec.? Cal. Yr/Plan Yr ? 4th Qtr Carry Over ? Out applies to In ? In applies to Out ?						
Co-Insurance: %/% (\$_____) Family stop __x (Agg/Spec ?) Out applies to In ? In applies to Out ?						
Rx: RX Card: Generic/ Brand/ Formulary Open Formulary? Closed Formulary ? Mail Order : Y/N Max (\$) ? days Co-Pay -Generic / Brand / Formulary						
Office Visit: SAAO ; 100%; Co-Pay ? Covered expenses ?						
2nd Sur Opn: Req Y/N ? Covered Opt? How Paid ?						
Surgery In-Pat: Facility: Professional Fees Pre. Cert. ?						
Surgery Out-Pat:? Facility: Professional Fees Pre. Cert. ?						
Anesthesia: If Non-Net & Surg In-Net - Penalty?						

MEDICAL REIMBURSEMENT PLAN - BENEFITS WORKSHEET - Page 2

Group Name _____ Broker _____ Effective Date _____

SAAO = Same as Any Other - Deductible and co-insurance applies, "in-Net" or "out of net" values as appropriate

BENEFIT	Prior Ins. Plan		New Ins. Plan		CAP PLAN	
	In-Network	Out-Of-Net	In-Network	Out-Of-Net	In-Network	Out-Of-Net
Out-Pat Hosp: Facility: Professional Fees						
In-Pat Hosp: Pre Cert ? Facility: Professional Fees						
Emer Rm: - Med Emerg- Facility: Professional Fees:						
Non-Med Emerg ?						
Urgent Care: Facility: Professional Fees:						
Ambulance:						
Maternity: Pre Cert ?						
Newborn: [Initial Hosp] Own Claim? Mother's ? Limits						
Well Baby: [Age 0 thru 1] Limits ?						
Well Child: [Age 2 thru 8] Exams ? Immunizations ? Limits ?						

MEDICAL REIMBURSEMENT PLAN - BENEFITS WORKSHEET - Page 3

Group Name _____ Broker _____ Effective Date _____

SAAO = Same as Any Other - Deductible and co-insurance applies, "in-Net" or "out of net" values as appropriate

BENEFIT	Prior Ins. Plan		New Ins. Plan		CAP PLAN	
	In-Network	Out-Of-Net	In-Network	Out-Of-Net	In-Network	Out-Of-Net
PREVENTATIVE CARE: <u>Mammography:</u> limits In Office Facility Professional Fees <u>PAP Test:</u> limits In Office Facility Professional Fees <u>PSA Test:</u> limits In Office Facility Professional Fees <u>Immunizations (Adult) :</u> limits ? <u>Routine Physicals (Adult) :</u> limits? Office DXL (ee notify)						
Supp. Acc.:						
DXL:Out- Pat.						
Pre. Cert. ?						
Home Health Care: Pre-Cert ? Limits?						
Skilled Nursing Facility: Pre-Cert ? Limits ?						
DME (Durable Med Equip): Pre-Cert? Limits ?						

MEDICAL REIMBURSEMENT PLAN - BENEFITS WORKSHEET - Page 4

Group Name _____ Broker _____ Effective Date _____

SAAO = Same as Any Other - Deductible and co-insurance applies, "in-Net" or "out of net" values as appropriate

BENEFIT	Prior Ins. Plan		New Ins. Plan		CAP PLAN	
	In-Network	Out-Of-Net	In-Network	Out-Of-Net	In-Network	Out-Of-Net
Mental/ Nerv. In-Pat.: Facility: Professional Fees Pre Cert ? Limits ?						
Mental/ Nerv. Out-Pat.: Facility: Professional Fees Pre Cert ? Limits ?						
Alcohol Abuse: <u>In-Pat:</u> Facility: Professional Fees Pre Cert ? Limits ? Combined with Other ?						
Alcohol Abuse: <u>Out-Pat:</u> Facility: Professional Fees Pre Cert ? Limits ? Combined with Other ?						
Drug Abuse: In-Pat: Facility: Professional Fees Pre Cert ? Limits ? Combined with Other ?						
Drug Abuse: Out-Pat: Facility: Professional Fees Pre Cert ? Limits ? Combined with Other ?						

MEDICAL REIMBURSEMENT PLAN - BENEFITS WORKSHEET - Page 5

Group Name _____ Broker _____ Effective Date _____

SAAO = Same as Any Other - Deductible and co-insurance applies, "in-Net" or "out of net" values as appropriate

BENEFIT	Prior Ins. Plan _____		New Ins. Plan _____		CAP PLAN	
	In-Network	Out-Of-Net	In-Network	Out-Of-Net	In-Network	Out-Of-Net
Allergy Shots: Injection: ? Vial: ? Limits ?						
Chiropractic: Limits						
Physical Therapy: SAAO; Co-Pay ? Limits						
Other Therapy: Speech? ; Hearing ? Pre-Cert. ? Limits						
TMJ: Limits ?						
Human Organ Trans: Limits ?						
Sterilization: Limits ?						
Infertility : Limits ?						
Credit for Deductible met: ?						
Credit for Co-Ins Met: ?						
Dependent Age: ? Student Requirement ?						
POLICY MAX						

MEDICAL REIMBURSEMENT PLAN - BENEFITS WORKSHEET - Page 6

Group Name _____ Broker _____ Effective Date _____

SAAO = Same as Any Other - Deductible and co-insurance applies, "in-Net" or "out of net" values as appropriate

BENEFIT	Prior Ins. Plan _____		New Ins. Plan _____		CAP PLAN	
	In-Network	Out-Of-Net	In-Network	Out-Of-Net	In-Network	Out-Of-Net
Other:						
Other:						
Other:						
Other:						
Other:						

The Preceding Pages Accurately Represent the Way that the Medical Reimbursement Plan Should be Administered.

Company (Group) Name _____ Officer's Name / Title _____

Signature

Date _____

Broker Signature _____ for Employee Benefit Concepts, Inc _____ Date _____

MEDICAL REIMBURSEMENT PLAN - BENEFITS WORKSHEET - Page 7

Group Name _____ Broker _____ Effective Date _____

SAAO = Same as Any Other - Deductible and co-insurance applies, "in-Net" or "out of net" values as appropriate

BENEFIT	CAP PLAN		Employer Initial
	In-Network	Out-Of-Net	
While Using a "Network" hospital and having no choice in the selection of the following professional specialties:			
ANESTHESIOLOGIST			
RADIOLOGIST			
PATHOLOGIST			
ER DOCTOR			
Where the carrier has several different kinds of contracts with Providers, it is possible for a provider to be listed in the carrier's provider lists <i>but NOT ACTUALLY be "In-Network"</i> ; the patient has selected them based on their name being in the carrier's listing. <u>The carrier may pay them as "Non-Network"</u> .	NA		

Work Sheet Addendum.

Company (Group) Name _____ Officer's Name / Title _____

Signature

Date _____

Broker Signature _____ for Employee Benefit Concepts, Inc _____ Date _____

(Client company letterhead)

Dear _____ (Insurance Carrier Name) (date)

(Company name) has applied for group health insurance with your company, effective _____

We are requesting that **Employee Benefit Concepts, Inc.**, of Cuyahoga Falls OH, [herein known as EBC] be named as our "correspondent" for the purpose of receiving all claim correspondence and EOBs ("Explanation of Benefits"). Employee Benefit Concepts, Inc. will be administering a "Medical Reimbursement plan" for our company.

We agree to hold your company harmless for any errors or improper acts committed by EBC in the administration of claims under the medical reimbursement plan. Further, we agree to assure that copies of the (*insurance company's name*) EOB's are forwarded to employees upon completion of the adjudication and processing of their claims.

As "correspondent," EBC will forward to your company all forms and correspondence, relative to the administration of the group health plan. Responsibility for the proper and timely submission of administrative information to EBC rests with our company. EBC shall be held harmless for any consequences resulting from our failure to properly discharge these responsibilities.

The mailing address for EBC is: Employee Benefit Concepts, Inc.
PO Box 515
Cuyahoga Falls OH 44222

Sincerely Yours,

(Name and title)

[Sample letter from the Client to the Insurance Carrier]

[To be put on Client's Letterhead]

(For MMO Cases)

Date _____

Re: Group # _____ (if the client already had an MMO group #)

We are requesting that Medical Mutual of Ohio send Repricing Sheets to Employee Benefit Concepts, Inc., who is providing third party administrative services you us to administer a high deductible program. I you have any questions, please call me at _____

Sincerely,

(Signature of Client Official)

Authorization for Release of Insurance Information

Employer Name _____

_____ is authorized to release claims and/ or benefits information contained in the Explanation of Benefits (EOB's) about me and my dependents, if any, enrolled under identification number _____ (*the ss # of "eligible employee"*) to my employer's administrator, Employee Benefit Concepts, Inc., for the express purposes of tracking health, or dental, or vision benefit expenses and/ or administering the partial self-funding of benefits. I / we also authorize Employee Benefit Concepts, Inc. to share such information, as needed, at their discretion, with the Insurance Agent of Record who may be assisting in the administration of the partial self-funded benefits.

As the "eligible employee", I understand that, as a result of this authorization, the administrator will receive copies of the Explanation of Benefits and other information which may contain confidential information regarding the providers that I have seen and the amount that has been spent on my care. This authorization shall be honored continuously from the date of signature.

In addition I authorize providers of medical services to release medical information which will aid in the administration of partial self-funded benefits.

If I elect not to authorize the release of the above information, I understand that it will result in claims that cannot be reimbursed under my employer's medical reimbursement plan.

SIGNATURES REQUIRED

Signature of Eligible Employee

Signature of Spouse (Required, if to be insured)

Date

Date

Signature of Dependent Child (Children) Age 18 or over (Required, if to be insured)

[_____ Date ____] [_____ Date ____] [_____ Date ____]

Employee Name _____ Telephone ____--____--_____
(First, Last)

Address _____ City _____ Zip _____ State _____

Social Security Number _____ Date of Birth _____ Date of Hire _____

Dependents

Name (First, Last)

Social Security

Date of Birth

Spouse

Child _____

Child _____

Child _____

Child _____

Child _____

Medical Reimbursement Program

Employer's Name _____

OTHER INSURANCE INFORMATION

1. Employee Name _____ SSN _____ Date of birth _____ Home phone # _____

2. Spouse name _____ Social Security Number _____ Date of birth _____

3. Is spouse employed _____ If yes, name of employer _____ Phone # _____

4. Does spouse's employer offer health insurance _____

Name of insurance company _____ Policy number _____

5. Who is covered by **spouse's employer's health insurance plan**: (please check appropriate boxes)

You eff. date _____ Spouse eff. date _____ Dependent children No one

Dependent Children Names:

Name _____ DOB _____ eff. date _____ Name _____ DOB _____ eff. date _____

Name _____ DOB _____ eff. date _____ Name _____ DOB _____ eff. date _____

Name _____ DOB _____ eff. date _____ Name _____ DOB _____ eff. date _____

6. IS ANYONE COVERED BY: MEDICARE MEDICAID VA OTHER STATE or FEDERAL PLAN

7 WHO IS COVERED : (please check appropriate boxes and indicate which coverage)

You eff. date _____ Spouse eff. date _____ Dependent children eff. date _____

8. No family member has other coverage

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility, attorney, insurance company, or other involved entity to disclose to Employee Benefit Concepts, Inc. and their authorized representatives: information regarding diagnosis, treatment, and prognosis, pertaining to medical history and physical or mental condition, and payments billed or received, in regard to the above Insureds. I understand that the information so acquired will be used to evaluate my claim for insurance benefits. A photographic copy of this authorization will be as valid as the original.

Employee's Signature _____ Date _____

Spouse's Signature _____ Date _____

Please mail or fax this sheet PLUS a copy front and back of **OTHER CARRIER'S ID CARD** to :

Employee Benefit Concepts, Inc.
PO Box 515 Cuyahoga Falls OH 44222
Fax 330-923-1933 phone 1-800-247-3711

**CLAIMS ASSUMPTION PROGRAM
ADMINISTRATIVE SERVICE AGREEMENT
ADDENDUM
CHECK WRITING SERVICE AGREEMENT**

EMPLOYER: _____ **Effective Date** _____

The *Employer* named above desires that the *Administrator* provide the **Check Writing Service** described below in connection with the administration of a Medical Reimbursement Plan.

The purpose of this agreement is to define the arrangement whereby the Administrator will write claim reimbursement checks to employees for the Employer's Medical Reimbursement Plan.

Employer Responsibilities:

1. Maintain a bank account solely for the Medical Reimbursement Plan
2. Authorize the *Administrator* to purchase computer checks from Quicken for that account and reimburse the *Administrator* for the cost of those checks. The selection criteria & current cost for checks will be provided when this option is selected. Checks will show the *Employer* name, address and the words "Medical Reimbursement Plan"
3. Sign all checks, as *Administrator* will **NOT** have access to the funds

Administrator's Responsibilities:

1. Prepare claim reimbursement checks for claims processed under the *Employer's* Medical Reimbursement Plan:
2. We will prepare the checks, payable to the employee, showing the employee's name and address on the left side of the check face so that it will show through on a standard left windowed # 10 envelope.
3. Checks will be made payable to the **Employee** unless the "Assignment" Option is chosen, then the check will be made payable to the provider where appropriate. [See "Assignment" agreement for details]
4. Normally check cycles will be run every 4 weeks
5. Mail checks to the *Employer* for signature and distribution to employees.
6. Mail the check register report to the employer. The report shows the check number, the check date, the amount and the payee.
7. Mail the EOB and voucher portion of the check to the Employee at home.

for the Employer

Date _____

Employee Benefit Concepts, Inc.

Date _____

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**CLAIMS ASSUMPTION PROGRAM
ADMINISTRATIVE SERVICE AGREEMENT
ADDENDUM
ASSIGNMENT of BENEFITS SERVICE AGREEMENT**

EMPLOYER: _____ **Effective Date** _____

The *Employer* named above desires that the *Administrator* provide the **Check Writing Service with the "Assignment of Benefits" feature** described below, in connection with the administration of a Medical Reimbursement Plan.

The purpose of this agreement is to define the arrangement whereby the Administrator will write claim reimbursement checks for the Employer's Medical Reimbursement Plan, payable to **providers**.

Administrator's Responsibilities:

1. Prepare claim reimbursement checks for claims processed under the *Employer's* Medical Reimbursement Plan payable to the provider, showing the provider's name and address on the left side of the check face so that it will show through on a standard left windowed # 10 envelope.
2. Checks will be made payable to the **NETWORK Provider**; If the provider is **not a NETWORK** provider, the checks will be made payable to the employee.
3. Provide 1099 information to the Employer for each **NETWORK** provider paid under the MRP Plan; including the amounts paid, the tax ID #, and the address.
4. Mail top portion of the checks to **Employer** for signature along with a modified check register [Employer will return signed checks.]
5. Distribute EOBs to Employees ; match up vouchers and checks and mail to Providers

Employer Responsibilities:

1. Sign the "Check Writing Agreement" and comply with the requirements of that agreement. [Please note that there is an additional monthly fee of **\$2.50 per month per employee** for this service]
2. Sign all checks, as *Administrator* will **NOT** have access to the funds
3. Return the signed checks to Employee Benefit Concepts, Inc for mailing to providers.
4. Prepare and mail 1099's to medical providers at the appropriate time.

_____ Date _____ **Employee Benefit Concepts, Inc.** _____ Date _____
for the Employer

I DO NOT WANT THE ASSIGNMENT OF BENEFITS FEATURE !

_____ Date _____ _____ Date _____
for the Employer **Employee Benefit Concepts, Inc.**

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**CLAIMS ASSUMPTION PROGRAM
ADMINISTRATIVE SERVICE AGREEMENT
ADDENDUM
SCHEDULE of FEES**

EMPLOYER: _____ **Effective Date** _____

The following administrative fees will be paid by the above named *Employer* to Employee Benefit Concepts, Inc. for the services described in the attached Administrative Service Agreement for the attached Medical Reimbursement Plan. The Setup Fee(s) and initial monthly service fees are due and payable at the time of the signing of the administrative agreement.

SETUP FEE(S)	\$	\$	\$	\$	\$
	Medical	Dental	Vision	W.I.	TOTAL

MONTHLY ADMIN. FEE(S)

Health Claims (includes check writing)		\$ _____ per month/ covered employee
Dental Claims		\$ _____ per month/ covered employee
Vision Claims		\$ _____ per month/ covered employee
Weekly Indemnity Claims		\$ _____ per month/ covered employee
*Assigned Benefits Extra Fee	[\$2.50]	\$ _____ per month/ covered employee
No Check Writing, Credit	[-\$.50]	\$ _____ per month/ covered employee

- Assignment fee varies for
- larger groups

The above monthly fee schedule will be in effect for the 12 month period beginning on the above effective date unless there is a change in the plan of benefits or in the insurance carrier.

the *Employer*

Date _____

Employee Benefit Concepts, Inc.

Date _____

FIRST MONTH'S INVOICE

Setup Fee(s)				\$ _____
Health Claims	_____ EE @ _____	=	\$ _____	
Assigned Benefits Extra Fee	_____ EE @ _____	=	\$ _____	
No Check Writing, credit	_____ EE @ _____	=	\$ _____	
Dental Claims	_____ EE @ _____	=	\$ _____	
Vision Claims	_____ EE @ _____	=	\$ _____	
Weekly Indemnity Claims	_____ EE @ _____	=	\$ _____	
	\$ _____			
Total Monthly Fees				\$ _____
TOTAL DUE				\$ _____

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CAP ADMINISTRATION SETUP CHECK OFF LIST

1. Group full **Legal Name** _____
2. EBC Effective Date _____ Insurance Effective. Date _____
3. Mailing Address _____

4. Telephone _____ Fax _____ E-Mail _____
5. Contact Name _____ Position _____
- Broker Name _____ Agency Name _____ Phone _____
- Fax _____ E mail _____ Tax ID _____

-
6. Copy of **prior insurance** carrier's schedule of benefits **and** Employee booklet (Cert.)
 7. Copy last month's billing Copy of Employer Application
 8. **Copy of:** EE applications Signed EE Authorization for Release of Info (*includes EE+ Family info*) (EBC form)
Employee signed "Other Insurance Information" forms
 9. Copy **New EE Certificate** of Coverage Copy Front & Back **new ID card** Copy Front & Back **EBC ID card**
 - Group Number _____ Waiting Period for new hires _____

EBC Documents

10. Signed CAP Administration Agreement Signed MRP Agreement
11. "Correspondent Letter" to carrier
12. Signed Benefits Worksheet Employee Meeting held Benefit Highlight Sheet(s) EBC ID cards
- Employees advised to send in Prior Carrier Deductible credit

If Applicable

13. Signed Check Writing Agreement Signed Assignment of Benefits Agreement
14. Signed Dental Plan Agreement Vision Plan Agreement W.I. Plan Agreement

15. Signed Schedule of Fees

16. Check to EBC for Set Up Fee(s) + 1st month's Adm. Fees

Indicate "NA " if not applicable

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