MEMBERS HEALTH PLAN
A health benefits trust for Texas law firms

919 Congress Ave Suite 720 ◆Austin, TX 78701
www.membershealthplan.com

HEALTH PLAN PARTICIPATION REQUEST/CONTRACT

AABN # _____ Account #: _____

SECTION 1 - EMPLOYER DATA

1. Full Legal Business Name: _____
2. Street Address: _____ City: _____ State: _____ Zip Code: _____
3. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
4. Group Phone: _____
5. Federal Tax ID No: _____ Type of Business: ☐ Sole Prop ☐ C-Corp ☐ S-Corp ☐ Partnership
6. Industry: _____
7. Administration Contact Person: _____ Email Address: _____
8. Executive Contact Person: _____ Email Address: _____
9. List prior insurance carrier or Third Party Administrator (TPA):_____

MEDICAL Current group health plan (check one): ☑ Fully Insured ☐ Self Funded ☐ Partialy Self Funded ☐ N/A

If this plan is replacing current group coverage, please provide your most recent copy of your invoice.

10. Name of Worker's Compensation carrier: _____

11. ☐ Yes ☐ No Are any persons to be covered NOT also covered by worker's compensation?
If Yes, please attach the names and reason for each.

12. ☑ Yes ☐ No Are you subject to COBRA? (You are subject to COBRA if you employed at least 20 full-time employees on at least 50% of the working days during the previous calendar year. PT employees are partially credited.)

SECTION - 2 EMPLOYEE DATA

1. Employee Probationary Period: ☐ 30 Days ☐ 60 Days
2. Coverage Effective Date: ☑ First day of the month after completion of probationary period
3. Waive Waiting Period: ☐ Select if you wish to waive the waiting period for employees in their probationary period during initial enrollment of the group.
4. Coverage Termination Date: ☑ First day of the month after termination

SECTION 3 - INITIAL PLAN SELECTION

MHP Medical Plan Options: Choose your plan options (based on Participation Requirements from Assumption page)

☐ Plan 1 - TX PLATINUM 500 90/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 2 - TX GOLD 1500 80/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 3 - TX SILVER 2500 70/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 4 - TX SILVER 3000 80/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 5 - TX SILVER 3000 70/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 6 - TX SILVER 5000 100/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 7 - TX SILVER 5000 80/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 8 - TX BRONZE 6850 PLUS 100/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 9 - TX BRONZE 6850 100/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

☐ Plan 10 - TX SILVER HSA 2700 80/50
☐ Rx5 ☐ Rx6

☐ Plan 11 - TX BRONZE HSA 6650 100/50
☐ Rx5 ☐ Rx6

☐ Plan 12 - TX BRONZE HSA 3500 70/50
☐ Rx5 ☐ Rx6

☐ Plan 13 - TX BRONZE 6550 100/50
☐ Rx1 ☐ Rx2 ☐ Rx3 ☐ Rx4

Rx Drug Plan **Descriptions**

Rx Plan 1 - $10 / $30 / $75 / 30%
Rx Plan 2 - $20 / $50 / $75 / 30%
Rx Plan 3 - $20 / $75 / $100 / 50%
Rx Plan 4 - $10 / $30 / $75 / 30%
Rx Plan 5 - 20% after Deductible
Rx Plan 6 - No Charge after Deductible

SECTION 4 - BILLING INFORMATION

1 Billing Address: _____
Street Address Suite City State Zip

2 Billing Contact Name: _____ Billing Contact Phone: _____

3 Direct Debit from Bank Account Bank Name: _____

ABA Routing #: _____ Account #: _____

SECTION 5 - BILLING & COLLECTIONS GUIDELINES

Although the contract period is one year, payment of the Health Care Fee will be required monthly. The following guidelines will be used for the Billing and Collection of the Health Care Fee:

1. Bills will be generated on the 1st of the month prior to the billing month.
2. Payments will be deducted on the 9th business day of every month.
3. If payment is not received, or moneys are not available for debit from a bank account by the end of the 31-day grace period, all coverage for a Participating Member/Group's covered employees may be terminated retroactive back to the 1st of the month for which payment was due and the Participating Member/Group will be responsible for any Health Care Fees that are due until the earlier of the end of the contract period or by providing the Trust with the proper termination notice as provided for in Section 6. Reinstatement will not be permissible for a Participating Member/Group for 12 months from the Termination Date.
4. If the Plan receives payment within 2 weeks after the Final Termination letter is sent and the account is paid through the current month, the group will be considered for reinstatement if this is the first instance the group is terminated for non-payment. Subsequent instances of termination for non-payment will not be considered for reinstatement.
5. The Plan will enforce a fee of $100.00 to any group that is reinstated after termination for non-payment.
6. As a condition of reinstatement, the group must enroll into the ACH Direct Debit process by e-mailing a copy of a voided check and authorizing us in the email to debit their account on a monthly basis.
7. A $35.00 NSF Fee will be posted to the next invoice if there are unavailable funds in the given account.
8. Employee and/or dependent terminations must be sent to the Plan Administrator prior to the termination date. If a termination request is received more than 15 days after the termination date, the employee and/or dependent will not be terminated until the end of the month in which the termination is received and the employer will be responsible for any applicable Health Care Fees. Employers are ultimately responsible for confirming terminations are received by the Plan and should review their bills each month.
9. Billing will be based on the current census of employees enrolled in our system. Upon enrollment if quoted membership changes more than 10% from the original quote or if the group's membership changes more than 10% during the year, the Plan reserves the right to requote. The rate structure is subject to change at any time.

By signing this contract, the applicant understands that failure to pay Health Care Fees in accordance with the "Billing and Collections Guidelines" will result in the termination of this contract and that it will be responsible for Health Care Fees due.

SECTION 6 - EFFECTIVE DATE/DEPOSIT

Deposit must include the first month's estimated health care fees.

Requested Effective Date: _____ Deposit with Application: $_____

IMPORTANT: Coverage is not in effect until the undersigned receives written approval from Member Benefits. (MB). No action is taken on the Application until after all required information is submitted. No person other than an officer of MB has the authority to bind this contract and the undersigned agrees that any such attempt by the agent is void and not effective.

SECTION 7 - PLAN TYPE & EMPLOYEE COVERAGE

The applicant requests participation for _____employees (enter approximate number of employees, including owners enrolling for coverage). Enrollment material will be provided to the applicant for distribution to eligible employees upon approval of this Participation Request/Contract.

SECTION 8 - HEALTH CARE FEES

Exhibit A: Health Care Fees (rates) - effective from the Effective Date of Coverage above through Initial Contract Period. However, rates may be adjusted during the contract period should the claim expense and/or plan utilization exceed projections.

SECTION 9 - CONTRACT TERMS & TERMINATION OF CONTRACT

Contract Terms: The Renewal Date for this Plan is every 12 months. Renewal Rates will be provided at least 30 days prior to the Renewal Date. Coverage will be automatically renewed for additional one-year (1) contract periods (Renewal Contract Periods) by payment of the applicable Health Care Fee due every month, provided the group continues to meet eligibility requirements. Renewals will be on the same terms and conditions as those in effect for the Initial Contract Period, unless notified otherwise by the Plan.

Termination of Contract: *Participating Member's may terminate this Contract upon renewal by providing the Plan Administrator written notice within 15 days from the end of a Renewal Contract Period. Participating Member's may also terminate this Contract at any time by giving the Plan Administrator written notice at least 60 days in advance of termination date. If written notice is not provided 60 days in advance, the Participating Member will be responsible for Health Care Fees that would be due as if proper notice been provided, i.e., for the 60 day period.*

By signing this contract, the applicant agrees to pay the Health Care Fees (Exhibit A) as provided in Section 8, based on the census maintained by the Trustees for employees that are eligible for coverage under the benefit plan applied for through the end of the Initial Contract Period and, upon payment of revised Health Care Fees, any Renewal Contract Period. The applicant understands that each Renewal Contract Period will be for additional periods of twelve (12) months and at the Health Care Fees provided by the Trust 30 days prior to the end of each contract period, subject to change as described above.

SECTION 10 - SUMMARY OF BENEFITS AND COVERAGE (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting www.membershealthplan.com. A hard copy of the SBC can also be provided upon request, please call the Plan at 800-282-8626 for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit www.healthcare.gov

SECTION 11 - STATEMENT OF CONTINGENT LIABILITY

This is a fully assessable benefit plan. In the event that the Trust is unable to pay its obligations, Participating Members in the Trust shall be required to contribute on a pro rata earned contribution basis the funds necessary to meet any unfilled obligations.

SECTION 12 - PARTICIPATION REQUEST

The applicant requests participation for its employees in the Trust. The applicant also agrees to be bound by all the conditions of participation and further agrees that:

1. Neither this request to participate, nor the payment of any moneys to be applied towards contributions for coverage, shall cause coverage to become effective on any of the applicant's employees. In order for coverage to go into effect on the date specified by this Contract, the applicant must be accepted as a Participating Member and the applicant's employees must satisfy the applicable eligibility requirements.
2. If applicable, the applicant must be a member in good standing with its association when applying for participation in this Trust, must meet membership requirements established by the by-laws of its association and must remain a member in good standing with its association for coverage to stay in effect.
3. The applicant has seen a copy of the benefits proposed and agrees to pay the required contributions (Health Care Fees) to the Trustees when due and in accordance with the Billing & Collections Guidelines. The Applicant further agrees to give all eligible employees an opportunity to enroll for coverage, if contributions from employees are required.
4. The coverage is subject at all times to the benefit plan applied for, which alone constitutes the contract under which benefits become payable.

Acceptance of this request is subject to all of the Trustees' requirements, including the provisions of any Administrative Services Agreement between the Trustees and any third party administrator, but only to the extent such provisions apply to rights and/or obligations applicable to employers accepted as Participating Members in the Trust, and the terms of the applicable benefit plan. The Trustees will notify the applicant of the approval or disapproval of this request. A notice of approval will specify the effective date of the applicant's participation in the Trust. If the applicant is accepted as a Participating Member, it will receive the appropriate benefit plan descriptions and material for enrolling its employees.

The applicant hereby requests participation in the Trust and agrees to be bound by its terms and conditions and the terms and conditions of the Administrative Services Agreement mentioned in the prior paragraph (to the extent they apply to Participating Members).

Name of Applicant (Please Print): _____

Signed: _____ **Date**: _____

SECTION 13 - To be filled out by the Trust

☐ Applicant has been Accepted and has met all participation requirements. Coverage will become effective as to applicant's eligible employees on _____, 20_____.

☐ Applicant has been declined and has not met one or all of the participation requirements.

Signed: _____ **Date**: _____

American Association of Business Networking

Send Forms to Administrator:
Member Benefits
7645 Gate Parkway, #101, Jacksonville, FL 32256
Email: support@memberbenefits.com
Facsimile (904) 396-2091

Corporate Membership Agreement Form

PLEASE CHECK REASON FOR COMPLETING: ☐ INITIAL APPLICATION ☐ MEMBERSHIP CHANGE

APPLICANT'S INFORMATION:

Name of Business	**Name of Business Voting Representative** (Last, First, MI)	# of Full-Time Employees

Applicant's Street Address	City	State	Zip

Primary Contact E-mail Address: (Important, your association documents will be emailed to this address.)	Phone #:	Business Type/Industry:

MEMBERSHIP DUES

$8.25 PER MONTH ($99.00 PER YEAR)

SELECT DUES PAYMENT METHOD

☑ Monthly Auto-Pay Include a VOID check and complete the Authorization below.

I hereby authorize Member Benefits (dues billing administrator) to initiate debit entries and to initiate, if necessary, credit entries as adjustments for any debit entries in error to my Checking account and the Financial Institution named below to debit and/or credit the same account. Member Benefits will not be held responsible for a membership termination due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority is to remain in full force and effective until Member Benefits and the Financial Institution have received written notice from me of its termination in such time and manner as to afford Member Benefits and the Financial Institution a reasonable opportunity to act on it.

Signature of Accountholder	Date	Name of Financial Institution
X		

ABN Membership Agreement: I hereby enroll for the Corporate Membership category in the American Association of Business Networking (ABN). Upon completion of this enrollment form, approval of my membership application, and payment of initial dues, I understand that: (a) my company and our actively at work, full-time, employees will be entitled to ABN's benefits; (b) ABN benefits may change from time to time; (c) ABN dues may change from time to time; (d) my membership will become effective on the day this enrollment form is dated, signed, and my initial dues payment is received; (e) I am eligible to apply for other ABN benefits; and (f) I authorize the release of my name and address listed on this Application for Insurance to ABN.

Signature of Applicant Representative	**Date**
X	

ABN is a not for profit association, not insurance.