Benefit Health Plan, Inc
ADMINISTRATORS

Third Party Administration

Group Implementation Setup Documents

Please complete the implementation form, as well as provide copies of the following information to ensure a smooth implementation.

Implementation Checklist to be collected from Group:

- Completed Group implementation worksheet.
- Copy of completed employee application forms.
- Copy of Previous Summary Plan Description
- Completed Agency/Agent/Broker agreement.
- Completed HIPAA Business Associate agreement.
- Completed Administrative Service Agreement.

	NAME	EMAIL
Carrier Executive	Bill McClure	bill@benefitlogistics.com
Broker		
Account Executive		
Client HR/Payroll Contact		
Client Incident Contact		

EMPLOEYR INFORMATION

(PLEASE PRINT)	Date:
Company Name:	Effective Date:
Phone:	EIN Number:
Phone:	Fax:
SIC/Industry:	# Employees:	Company Type **LLC ( ) S Corp ( ) C Corp ( ) 501C ( ) State: ____**

Primary Contact

Name:	Title:
Address:	Phone Number:
Email:	Fax:

Send Billing Information To:

Name:		Title:
Address:	Address 2:	Phone Number:
Email:	Billing Monthly/Claims will be paid weekly	Bank Name:
Funding Directions: Monthly Invoicing to Client will always occur on the 1st for the 1st time even for recurring billing KYC (Know Your Client).		
Account Number (Not needed if we bill client):		Credit Card Info/Exp Date/Zip/CVV:
ABA Routing Number (Not needed if we bill Client)		

AGENT / BROKER

Agent/Broker Name (Primary Contact):	Company Name:
Address:	Phone:
Email:	Fax:
Account Manager (Secondary Contact):	Phone:
Fax:	Email Address:

MEDICAL PLAN FEES / COSTS

Covered Classes of Employees **Management ( ) Non-Mangement ( ) Union ( ) Full Time ( ) Part Time ( ) Other ( )**

Min work hours to be eligible for Benefits:	New Hire Waiting Period: Date of hire ( ) or _____ Days Effective first of month following waiting period completion?

Rates / Benefits Description

	PLANS AND RATES		PLANS AND RATES	
Coverage Rate (Employer ER % or $ Amount)	Plan Name/Number:	Plan Name/Number:	Plan Name/Number:	Plan Name/Number:
Monthly Amt Employer will pay:				
Employee				
Employee & Spouse				
Employee & Child(ren)				
Family				
Other				
**See attached				

HSA

Additional employer HSA contribution: $_____

( ) Employee
( ) Employee + Spouse
( )Employee + Child(ren)
( )Family

COBRA

Cobra Administration: **BHPI ( ) Client ( ) Other ( )**	Name of current COBRA Participants:
Initial COBRA rights letter (NEW HIRE) **BHPI ( ) Client ( )**	COBRA Election form: **BHPI ( ) Client ( )** **PROVIDE COPY

Current COBRA Members

Name	Address	Qualifying Event Date	Tier (Single/Family)	Paid Through

Group Medical Questionnaire

Company Name:	Industry:	SIC Code:
Address:	City/State:	Zip:
Producer Name:	Producer Firm:	Phone:
Renewal Date:	ER Contribution % EE___ Dep___	Eligibility Period _____ Days
5 Year Carrier History Carrier: _____ Eff. Date: _____ Carrier: _____ Eff. Date: _____ Carrier: _____ Eff. Date: _____	Current Rates: EE Only _____ EE/Spouse_____ EE/Child _____ EE/Fam _____	Renewal Rates: EE Only _____ EE/Spouse_____ EE/Child _____ EE/Fam _____

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents.
IMPORTANT: Your answers must include all COBRA and State Continued Individuals covered by your current plan.

Yes	No	A.	Are any employees, dependents or COBRA continuees considered disabled?
Yes	No	B.	Are any covered persons contemplating treatment or hospitalization, been advised to seek treatment, or been scheduled for hospitalization and / or surgery?
Yes	No	C.	Are any covered persons pregnant? If yes, how many? _____
Yes	No	D.	Has any employee missed 10 or more consecutive days of work in the last 12 months due to injury or illness?
Yes	No	E.	Has the Group or Producer/Agent requested and/or received paid claim information within the past 6 months from the current carrier? If yes, please provide all claim information received.
Yes	No	F.	Within the past 12 months, has any covered person had a serious continuing claim (i.e., chronic, or ongoing condition likely to cost $25,000 or more per year for treatment) due to a mental or physical disorder? If yes, check the appropriate box(es) below.

Group Medical Questionnaire

	Aids/Immune disorders		Cardiovascular		Infertility		Neurological
	Alcohol Abuse		Diabetes		Intestines		Pancreas
	Arthritis		Drug/Substance Abuse		Kidney		Skin
	Back, Neck		Epilepsy		Liver		Stomach
	Blood		Ears/Eyes		Lungs		Stroke/Paralysis
	Bone/Joint		Emphysema/Pulmonary		Lupus		Venereal
	Brain		Heart Disease		Mental/Nervous		Other (detail below)
	Cancer/Tumor		High Risk Pregnancy		Migraines		

If you answered "yes" to questions A, B, C, D or F, please provide the following information for each individual with a likely serious continuing condition. Use an additional sheet if necessary.

EE, Dep or Continuee	Age	Nature of Condition	Dates of Treatment	Names of Medication	$ Amount of Prior Claims	Current Status

I represent to the best of my knowledge the information I have provided is accurate. I understand that My Agent/Agency will rely on this information to determine whether a proposal will be issued. If errors or omissions are subsequently found, we reserve the right to revise rates or rescind the quote.

Employer Contact Name/TItle	Signature	Date

Signatures

The undersigned authorizes BHPI, Inc. to implement this Plan according to the plan parameters outlined. Changes will be made in writing and submitted to BHPI indicating the effective date of change by an authorized Plan Representative.

Authorized Signature for Plan Sponsor

Name (Please Print)

DATE

Authorized Signature for TPA / Broker

Name (Please Print)

DATE

Authorized Signature for Agency/Agent/Broker

Name (Please Print)

DATE

Authorized Signature for Witness

Name (Please Print)

DATE

HIPPA Business Associate Agreement

This HIPAA Business Associate Agreement ("Agreement") is made effective as of _____, 20____, by and between _____ [Employer] ("Covered Entity"), of _____ [Address] and BHPI ("Business Associate"), of 99 King St Ste 150 St. Augustine, FL 32085 [Address], (collectively, the "Parties").

WHEREAS, Business Associate, in connection with its services, may maintain, transmit, create, or receive data for or from Covered Entity that constitutes Protected Health Information ("PHI").

WHEREAS Covered Entity is or may be subject to the requirements of the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and related regulations;

WHEREAS, with respect to the foregoing, Business Associate is or may be subject to the requirements of HIPAA, HITECH, and related regulations;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties hereby agree as follows:

1. **Definitions**
    a. **General**: The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic Protected Health Information, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

b. **Specific**:

i. **Business Associate**: "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean BHPI [Business Associate].

ii. **Covered Entity**: "Covered Entity" shall generally have the same meaning as the term "covered entity"at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean [employer name] _____ [Covered Entity]

iii. **Electronic Health Record**: "Electronic Health Record" shall have the same meaningas the term "electronic health record' in the HITECH Act, Section 13400.

iv. **HIPAA**: "HIPAA" collectively refers to the HIPAA Statute, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, the HITECH Act, and any associated Regulations, as such may be amended from time to time.

2. **Obligations and Activities of Business Associate**:

a. Business Associate agrees to not use or disclosePHI other than as permitted or required by the Agreementor as required by law.

b. Business Associate agrees to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement.

c. Business Associate agrees to report to Covered Entityany use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware.

d. In accordance with 45 CFR 164.502(e)(1) and 164.308(b)(2), if applicable, Business Associate agrees to ensure that any subcontractors that create, receive,maintain, or transmitPHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

e. a.In accordance with 45 CFR 164.524, Business Associate agrees to make available PHI in a designated record set to the Covered Entity within 30 days of a request by Covered Entity for access to PHI about an individual. In the event that any individual requestsaccess to PHI directly from Business Associate, Business Associate shall forward such request to Covered Entity within 30 days of receiving such request.

f. In accordance with 45 CFR 164.526, Business Associate agrees to make any amendment(s) to PHI in a designated record within 30 days of a request by Covered Entity.Business Associate shall provide such information to Covered Entity for amendment and incorporate any amendments in the PHI as required by 45 CFR 164.526. In the event a request for an amendment is delivered directly to Business Associate, Business Associate shall forward such request to Covered Entity within 30 days of receiving such request.

g. Except for disclosures of PHI by Business Associate that are excluded from the accounting obligation as set forth in 45 CFR 164.528 or regulations issued pursuant to HITECH, Business Associate shall record for each disclosure the information required to be recorded by Covered Entities pursuant to 45 CFR 164.528. Within 30 days of notice by Covered Entity to Business Associate that it has received a request for an account of disclosures of PHI, Business Associate shall make available to Covered Entity, or if requested by Covered Entity, to the individual, the information required to be maintained pursuant to this Agreement. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall forward such request to Covered Entity within 30 days of receiving such request.

h. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate agrees to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).

i. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary for purposes of determining compliance with HIPAA.

3. **Permitted Uses and Disclosures by Business Associate**

a. Business Associate may use or disclose PHI for the following purposes: (Check one)

i. ☐ As necessary to perform the services as agreed to between the Parties, notwithstanding the restriction on such uses and disclosures as set forth in HIPAA and this Agreement.

ii. ☐ Other.

_____

_____

b. Business Associate may only de-identify PHI if permitted by Covered Entity and in any event may only de-identify PHI in accordance with 45 CFR 164.514(a)-(c).

c. Business Associate may use or disclose PHI as required by law or where Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity except for the specific uses and disclosures set forth herein.

4. **Permissible Requests by Covered Entity**

a. Except as otherwise permitted by this Agreement, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by Covered Entity.

5. **Term and Termination**

a. **Term**: The Term of this Agreement shall be effective as of the date of signature below, and shall terminate on the date the business relationship, or any servicesagreements, between the Parties end or are terminated or on the date Covered Entity terminates for cause as authorized in paragraph (b) of this Section

b. **Termination for Cause**: Business Associate authorizes termination of this Agreement by Covered Entity, if Covered Entity determines Business Associate has violated a material term of the Agreement and Business Associate has not cured the breach or ended the violation within 90 days written notice.If it is determined by the Covered Entity that cure is not possible, Covered Entity may immediately terminate this Agreement. The termination of this Agreement shall automatically terminate the business relationship and any services agreements between the Parties.

c. **Obligations of Business Associate Upon Termination**: Upon termination of this Agreement, Business Associate shall either return or destroy all PHI that Business Associate still maintains in any form. Business Associate shall not retain any copies of such PHI. In the event Business Associate determines that returning or destroying the PHI is infeasible, the terms of this Agreement shall survive termination with respect to such PHI and limit further uses and disclosures of such PHI for so long as Business Associate maintains such PHI. In addition, Business Associate shall continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI for as long as business associate retains the PHI.

d. **Survival**: The obligations of Business Associate under this Section shall survive the termination of this Agreement.

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6. **General Provisions**

a. This agreement sets forth the entire understanding of the Parties. Any amendments must be in writing and signed by both Parties. This Agreement shall be construed under the laws of the State of Florida, without regard to conflict of law provisions. Any ambiguity in the terms of this Agreement shall be resolved to permit compliance with HIPAA. Any references in this Agreement to a section in HIPAA means the section as in effect or as may be amended. This Agreement may be modified or amended from time to time as is necessary for compliance with the requirements of HIPAA and other applicable law. Amendments must be made in writing and signed by the Parties. The failure of either Party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that Party's right to subsequently enforce and compel strict compliance with every provision of this Agreement. The terms of this Agreement are hereby incorporated into any service or business agreement that may be entered into between the Parties with the intent to form a business relationship. In the event of a conflict of terms between this Agreement and any such service or business agreement the terms of this Agreement shall prevail.

IN WITNESS WHEREOF, I have hereunto set my hand to this HIPAA Business Associate Agreement as of the date set forth above.

Covered Entity

_____

By: _____

Title: _____ Date: _____

Business Associates

_____

By: _____

Title: _____ Date: _____

Third Party Administrative Service Agreement

This Agreement is made as of this ___ day of _____, 20___ by and between _____ (Hereinafter referred to as Employer), and Benefit Health Plans Inc. (hereinafter referred to as BHPI)

WHEREAS, The Employer has established any of the following:
All the marked:

____Employee Health Benefit Plan

WHEREAS The Employer desired BHPI to serve as Plan Supervisor to provide for the general administration, assessment, billing, eligibility, customer service, and consultation services to the Plan, and BHPI has indicated its willingness to do so, all pursuant to the terms of the Plan Document and this Agreement.

NOW THEREFORE, in consideration of the promises, covenants and conditions herein contained on the part of the Employer, BHPI does agree to provide as follows:

SECTION 1: ADMINISTRATIVE SERVICES

a. **BILLING SERVICES**: BHPI will provide statements for each division/facility/location of the Employer for each month or billing period. Premium and fee remittances made to BHPI will be promptly reconciled and forwarded to the appropriate insurance carriers and/or plan service providers if applicable. The billing statement will include the following information:
   i. Account name, address, and group number.
   ii. Participant name, dependent status, coverages, coverage premiums, and fees.
   iii. Adjustments for additions, deletions, and changes

b. **FILE MAINTENANCE**: Employer will be responsible for giving access to set up all initial employee/property/plans/documents/policies or any files, determining eligibility of Participants and Property and processing all additions, deletions, and changes in accordance with information provided on a monthly basis.

c. **CLAIM PROCESSING**: BHPI will perform the following claim processing functions:
   i. Compute benefits in accordance with the provisions of the Plan Document and Policies.
   ii. Correspond with interested parties including participants and providers to obtain necessary information for claims adjudication.
   iii. Prepare and distribute claims with an explanation of benefits.
   iv. Maintain information necessary to prepare and file Federal 1099 and provide information needed for filing 5500 forms.
   v. File and coordinate reimbursement for all stop-loss/reinsurance claims with the appropriate excess loss carrier.
   vi. Verify eligibility for providers.

d. **REPORTING SERVICES**: BHPI will provide the following reports to the Employer:
   i. Monthly reports outlining the complete activity of the Plan including all receipts and disbursements; and
   ii. Provide other detailed claim reports to assist in evaluating Plan performance, areas of Plan usage and other analysis of the Plan on an as needed basis.

e. **DOCUMENTS AND FORMS**: BHPI will provide the following:

i. Enrollment forms.

ii. Identification cards.

iii. Claim forms.

iv. Change forms.

v. Certificates of Coverage/Evidence of Insurability forms.

vi. Recommended Plan Document.

vii. Arrange for printing of Summary Plan Descriptions and Policies.

viii. Preparation and mailing of Federal 1099 forms.

f. Prepare any additional forms which may be necessary for the administration of Plans.

g. **AGENT OF RECORD**: This Agreement will acknowledge that BHPI shall act as our Third Party Administrator of Record for: obtaining, binding, or filing any insurance or reinsurance coverage; claims or claims data; or previous coverages through any carrier, ancillary providers such as dental, vision or voluntary benefits, or any stop-loss carriers and/or Managing General Underwriters to include any and all lines of insurance. I now appoint as my Co-Agent of Record William McClure of BHPI and has all rights and responsibilities for the procurement, binding, service, treatment, payment, and operations of the plans. All proposals previously released to other entities should be made available to BHPI and my Agent of Record.

This lettersupersedes any priorauthorization given and shall remain in force until canceled by the undersigned in writing with at least 60-day notice. If cancelled, all included/embedded third party products shall be un-embedded and the client shall be billed market rates by any continuing coverage through BHPI.

SECTION 2: CONSULTING SERVICES

a. **PLAN DESIGN**: BHPI will A.assist the Employer in reviewing policies, benefits, utilization reports and other data to determine appropriate Plan design considerations, plus coordinate such considerations with the appropriate underwriting for rating.

b. **UNDERWRITING**: BHPI will perform underwriting evaluations for Plans and will make recommendations to the Employer regarding such entrant's eligibility.

c. **HIPAA PRIVACY**: BHPI will work with the Compliance Officer regarding Privacy Policies and agrees to work with the business associates of the Plan.

SECTION 3: GENERAL PROVISIONS

a. The Employer agrees to provide the funds necessary to discharge its liability under the Plan agreements as determined by BHPI.

b. The Employer agrees to furnish BHPI with all information required with respect to employees and dependents eligible, and eligible property, to participate in Plans and all changes regarding the status of such Participants.

c. The Employer agrees to indemnify and hold harmless BHPI against any loss, damage, expense, or other liability arising in connection with the Plan including legal fees occasioned by claims, demands, lawsuit or administrative proceedings unless such liability arises out of the gross negligence, willful misconduct, or intentional breach of this Agreement by BHPI. Termination of this Agreement will not relieve the Employer from performance under this Section with respect to liability arising from events occurring during the terms of the Agreement.

d. The Employer agrees not to require BHPI to perform any services which would cause BHPI to be deemed a Trustee or Fiduciary, or which would constitute the practice of law, accounting, or any other profession regulated by the laws of any State or Federal Government. The Employer agrees to refer to their counsel or tax accountant all questions concerning the status of self-insurance underState, Federal or local tax laws.

e. This Agreement may be terminated by either party's written notice. Such written notice shall be given sixty (60) days in advance if such termination is effective on a date other than an anniversary of this agreement. For terminations of this agreement upon an anniversary of this agreement, such written notice is required prior to the anniversary date; if said termination is not received by the anniversary date, this agreement shall automatically renew for a period of one year. Upon termination of the Agreement and/or termination of the Plan, BHPI will, at the request of the Employer, continue to provide claims processing services for a period of three (3) additional months to complete the "run out" processing of claims incurred prior to such termination. The Employer agrees to pay a "run out" administrative fee to BHPI for each of the three (3) additional months. The "run out" fee shall be quoted at the time the employer selects this option. The Employer will continue providing sufficient funds to pay such claims. In the case of self-funding or level funding, the Employer understands that, to assure payment of claims received within the last month of the plan year, all required premiums must be paid, all claim forms, all bills for medical services provided and other documentation required by the plan to operate.

f. A.It is further understood that it is the responsibility of the Employer to make such transfers, at the end of the Plan year, as shall be required to permit payment under the definition of "Paid Claims" as in any reinsurance or stop-loss contract as may be issued in the name of the Employer.

SECTION IV: FEE STRUCTURE

I agree that fees will be paid to BHPI by the employer, in full, monthly as quoted in the plan proposal and or setup document or spreadsheet as presented in the Premiums.

PLAN DISCLOSURE NOTICE

The Department of Labor requires that certain disclosures be made to and approved by an independent plan fiduciary that has the authority to act for the plan. Specifically, prohibited transaction class exemption 84-24 (PTE 84-24) requires disclosure of all service fees, commissions or other income received by all interested parties relative to the plan. This notice has been prepared to satisfy the disclosure requirements of PTE 84-24.

BHPI is compensated through administrative services fees as described below:

Additional compensation to the TPA and/or broker relative to the plan takes the form of commissions and/or reinsurance service fees on insurance/reinsurance coverage which are reflected in the following schedule:

BHPI may be affiliated with the reinsurer whose contract has been selected/recommended and is not limited by any agreement with the insurer.

Fiduciary Acknowledgement

I hereby acknowledge that in any capacity as an independent fiduciary with authority to act on behalf of the plan, I have reviewed the Plan Disclosure Notice and I approve the transaction on behalf of the plan. I am not an insurance agent or broker, pension consultant or insurance company involved in the transaction. I will not receive directly or indirectly any compensation or other consideration from any party dealing with the plan in connection with the transaction.

Signed: _____ Dated: _____