National Restaurant Association

Restaurant & Hospitality Association Benefit Trust

Quote & Installation Checklist

6-9 enrolled employees & Virgin Cases

Submit the following documents to: RHAB_Trust@uhc.com

- **Email subject line**: RHABT – Group name – Effective Date
- **CC:** Your UnitedHealthcare Account Executive
- **CC:** Tonya Johnson
  - Email: Tonya_m_Johnson@uhc.com
  - PH: 763-361-4199

Requirements for Preliminary Rates (6-9 enrolled employees):

- Employer Information or UHC Quote Request Form
  - Company name/address/ATNE total/sic code/effective date
- Member level census (employees & dependents)
  - Employee, spouse & dependent: gender & date of birth

Requirements for Underwritten Rates:

- AHP Employee Enrollment Form + Health Addendum (Illinois)

Sold Case Installation Checklist:

- Submit all RHABT cases to: RHAB_Trust@uhc.com (Franchise Code: 7970000)
  - Subject Line: RHABT – Group Name – Effective Date (CC: Regional Account Executive – per above)
- AHP Individual Applications (Illinois) OR UHC Prime Enrollment Spreadsheet
- AHP Employer Application (Illinois)
- Quarterly Wage & Tax (6-10 eligible employees)
- Product & Benefit Selection Form
- Restaurant & Hospitality Association Benefit Trust Participation Agreement
- AHP Employer Certification
- COBRA Addendum
- Verification that Agent/Agency is licensed and appointed in Illinois
- Copy of Binder Check (payable to UnitedHealthcare) or Direct Debit Form
  - Please send only the original binder check to the below address for processing. Include the Tax ID number in the memo section of the check.

If Using Regular Mail:
UHS Premium Billing PO
BOX 94017
Palatine, IL
60094-4017

If Using Overnight Services:
UHS Premium Billing
Attn: Box 94017
5505 N. Cumberland Ave Ste: 307
Chicago, IL 60656-14

Please Note:

- *Agent and Agency must be licensed in Illinois to receive commission on RHABT business.*
- *The Restaurant & Hospitality Association Benefit Trust plans include a 2.05% service & access fee. This service fee will be included on the Monthly invoice as a separate line item and is not included in the UnitedHealthcare medical premium.*
- *Participation Requirements: 50% Participation, regardless of valid waviers*
- *SIC Code: 5812, 5813, 7011, 7032 & 7041*
- *Management Carve Out: There must be 6+ enrolled managers to qualify for a carve out. UnitedHealthcare requires 50% participation of eligible managers. Non-carve out employees cannot be placed in a separate UnitedHealthcare plan.*
- *Slice Business: Available in California only. Slice is only allowed between RHABT and Kaiser staff model HMO. Slice cannot be used in conjunction with carve out or any other type of membership split. There must be 12+ eligible employees with a minimum of 50% enrolled.*
- *Plans are not available to member employers in allstates.*
- *Groups with 2-5 & 51+ enrolled employees are competitively advantaged outside of the RHABT and will be quoted via the NRA Legacy program*

UnitedHealthcare
EMPLOYER & INDIVIDUAL

Restaurant & Hospitality Association Benefit Trust: Quote Request Form

All fields must be completed in order to process quote request send request to RHAB_Trust@uhc.com

Once submitted this Quote Request form is processed and will generate Preliminary Rates (Turn Around Time: 5-7 business days).
After the preliminary rates are released, we can move forward to underwriting (Turn Aroud Time: 3-5 business days).

Underwritten Rate Requirement: 6-9 enrolled employees + Virgin Groups: Individual applications + Employer Application.
10-50 enrolled employees: Employer Application (GRA Rating)

Group Information

Group Name			
Group Physical Address			
City		State	Zip
Group Contact		Phone	
Group Contact Email			
Group Tax ID		Group SIC Code	
National Restaurant Association/SRA Membership #		AAHOA Membership #	

National Restaurant Association/State Restaurant Assocaition membership # is not required to get a quote. Final Restaurant & Hospitality Association Benefit Trust rates are contingent that the firm is an active member of the NRA/SRA

Agency Information

Writing Agent			
Agency Name			
City		State	Zip
Email (Where To Send Quote)			

Group Size

Average Total Number of Employees (ATNE) Total number of W-2's issued in previous year	
Total Number of Eligible Employees	
Total Number of Enrolling Employees	
Total Number of Valid Waivers	

Valid waiver (FT Employees only): Spouse's Employer Sponsored Plan. Parent's plan to age 26, Medicare/Medicaid. TRICARE or VA or other employer coverage

Carrier History

Prior Carrier	
# of Years with Carrier	

Quote Request

UHC Account Executive			
Requested Effective Date			
Employer Contribution %		Employee	Dependents

Other Required Documents

Most Current Renewal Packet with Medical/Rx rates and plan designs		Yes/No
Dependent Level Census in Excel format listing all enrolling members: (First & Last Name, DOB, Gender, Home Zip, Relationship)		Yes/No
NRA Co-Branded Material		Yes/No

Member-Level Census

Internal Use Only	Auto Populated	These fields must be completed for all members (employees, spouses and children)							Optional
		E for Employee S for Spouse D for Children						EE for Employee Only ES for Employee + Spouse EC for Employee + Child(ren) F for Family	
SEQ	EE ID	REL CODE	LAST NAME	FIRST NAME	DOB	GENDER	ZIP	MED TIER	EE STATUS
Sample	1	E	Smith	John	6/1/1970	M	45111	ES	Active
	1	S	Smith	Jane	10/1/1972	F	45111		

Employee Enrollment Form for an Association Health Plan

Illinois

UnitedHealthcare®

Please fill out the entire enrollment form to avoid processing delay.
Please clearly print all information.

- [x] UnitedHealthcare Insurance Company
- [ ] UnitedHealthcare Insurance Company of Illinois
- [ ] UnitedHealthcare of Illinois, Inc.
- [ ] UnitedHealthcare Insurance Company of the River Valley
- [ ] UnitedHealthcare Plan of the River Valley, Inc.

Association Health Plan Name:

Group/Policy #	Employer Name	Requested Effective Date of Coverage / Date of Change

Employer Address (if more than one location)

Employee Type (check all that apply):
- [ ] Active [ ] COBRA [ ] State Continuation
  Start date ____/____/____
  End date ____/____/____
- [ ] Hourly [ ] Salary [ ] Union
- [ ] Non-Union [ ] Retired
- [ ] Other _____

Reason for Application / Change Request (check all that apply):
- [ ] New Group Plan [ ] New Hire [ ] Annual Open Enrollment
- [ ] Marriage [ ] Divorce [ ] Birth [ ] Adoption or Placement for Adoption
- [ ] Court Order [ ] Loss of other coverage (employee or dependent) [ ] Termination
- [ ] Returning to School Full Time [ ] Other_____

Date of Event: _____ (You may be required to provide proof of event.)

Enrollee Information

Enrollee Social Security Number	Last Name	First Name	Initial

Address	City	State	Zip Code

Date of Birth	Gender	Marital Status	Preferred Phone: [ ] Home [ ] Cell [ ] Work
	[ ] M [ ] F	[ ] Single [ ] Married	( ) –

Height	Weight	Email Address

Date of Hire	Hours Worked Per Week	Occupation	Are you an independent contractor?
			[ ] Yes [ ] No

Enrollee and Dependent Information (Only for those applying.)

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. [ ]

	Enrollee	Spouse	Child 1	Child 2	Child 3
First Name					
Middle Initial					
Last Name					
Gender		[ ] M [ ] F	[ ] M [ ] F	[ ] M [ ] F	[ ] M [ ] F
Date of Birth					
Social Security Number					
Height/Weight					
Primary Care Physician's Name	Existing Patient? [ ] Yes [ ] No	Existing Patient? [ ] Yes [ ] No	Existing Patient? [ ] Yes [ ] No	Existing Patient? [ ] Yes [ ] No	Existing Patient? [ ] Yes [ ] No
Primary Care Physician's ID number					

Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or Dental Benefit Providers of Illinois, Inc.
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Enrollee Name: _____

Coverage Selection	Please check the box for each coverage you or your dependents are enrolling in. If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	**Medical**	**Dental**	**Vision**	**Basic Life/AD&D**	**Supp Life/AD&D**
Enrollee	☐ _____	☐ _____	☐ _____	☐ $_____	☐ $_____
Spouse/Domestic Partner	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	**STD**	**STD Buy Up**	**LTD**	**LTD Buy Up**	Salary $ _____ Required only if Life, STD, or LTD based on salary
Enrollee	☐ $_____	☐ $_____	☐ $_____	☐ $_____	

Life Insurance Beneficiary (if applying for Life Insurance with UnitedHealthcare)

	Full Name and Address	**Relationship**
Primary		
Secondary		

Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)

	Enrollee	**Spouse**	**Child 1**	**Child 2**	**Child 3**
Currently Working Full Time	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Plan to Keep Other Insurance Coverage	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare / Medicaid	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Medicare/Medicaid Coverage Effective Date					

Prior Medical Coverage Information

☐ Yes ☐ No Have you or any dependents applying for coverage previously had coverage under your employer's group health plan?

If Yes:

Insurance Company Name _____ Phone # _____ Policy/Group # _____

Termination Date_____ Effective Date_____ Reason for Termination _____

Type of Plan: ☐ Prior Employer Group Plan ☐ Spouse's Employer Group Plan ☐ Individual Policy

☐ Other _____

Enrollee Name: _____

Signature

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows: I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I declare all statements contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 90 days that was provided to the Association Health Plan (AHP), are true and correct and that no material information has been withheld or omitted. I understand and agree that the AHP is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Plan Documents. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date.

Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

By signing below, I attest to the accuracy, truthfulness and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in rescission of the AHP coverage, termination of such coverage, an increase in the payment amount retroactive to the coverage date, or other consequences as permitted by law.

All pages must be attached and complete, including this authorization, for the enrollment form to be considered complete. Incomplete enrollment forms may be rejected.

Enrollee Signature _____ Date _____

Waiver (Please complete if you are waiving medical coverage.)

I waive medical coverage for:

☐ Myself ☐ Dependent Children

☐ Spouse ☐ Myself and all dependents

Please state reason for waiving coverage:

☐ Existence of other Qualifying Coverage _____

☐ Other reason _____

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 plan, 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.

Enrollee Signature _____ Date _____

Health Addendum to Employee Enrollment form for Association Health Plans

Illinois

UnitedHealthcare®

Enrollee Name: _____ SSN: _____

Medical History

Please answer completely and truthfully. Please note that if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective. All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.

United Healthcare Services, Inc. is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

Has anyone on this enrollment form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below.

1 Cancer/Tumor ☐ Yes ☐ No	☐ Breast ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Testicular ☐ Brain ☐ Ovarian ☐ Cervical ☐ Prostate ☐ Other Cancer ☐ Non-Malignant Tumor – Location of Tumor _____
2 Heart / Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐ Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Elevated Cholesterol/Triglycerides ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Angina ☐ Hemophilia ☐ Blood Clots ☐ Pacemaker/ICD ☐ Blood Disorder ☐ Sickle Cell Anemia ☐ Other _____
3 Reproductive ☐ Yes ☐ No	☐ Current Pregnancy (due date_____ if multiples #____) ☐ Pregnancy Complications ☐ Fibroids ☐ Menstrual Disorders ☐ Breast Disorders ☐ Endometriosis ☐ Infertility ☐ Other_____
4 Intestinal / Endocrine ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Cirrhosis ☐ Hepatitis B/C ☐ Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Gallbladder ☐ Gastric Bypass ☐ Other_____
5 Brain/Nervous ☐ Yes ☐ No	☐ Alzheimer's Disease ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy ☐ Parkinson's Disease ☐ Head Injury ☐ Cyst ☐ Other _____
6 Immune ☐ Yes ☐ No	☐ Scleroderma ☐ ALS ☐ Psoriasis ☐ AIDS ☐ HIV+ ☐ Lupus ☐ Immuno Deficiency ☐ Other _____
7 Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Sarcoidosis ☐ Lung Disorders ☐ Tuberculosis ☐ Sleep Apnea ☐ Chronic Bronchitis ☐ Pneumonia ☐ Other _____
8 Eyes/Ears/Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy ☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Other_____
9 Urinary/Kidney ☐ Yes ☐ No	☐ Kidney Stones ☐ Kidney Disorders ☐ Bladder Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Other _____
10 Bones/Muscles ☐ Yes ☐ No	☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Bulging/Herniated Disc ☐ Joint injury ☐ Fibromyalgia/Chronic Fatigue Syndrome ☐ Chronic Pain Syndrome ☐ Shoulder Disorder ☐ Knee Disorder ☐ Spina Bifida ☐ Back Disorder ☐ Neck Disorder ☐ Other _____
11 Behavioral Health ☐ Yes ☐ No	☐ Anxiety/Depression ☐ ADHD ☐ Bipolar Depression ☐ Manic Depression ☐ Schizophrenia ☐ Autism ☐ Eating Disorder ☐ Suicide Attempt ☐ Inpatient Alcohol/Drug ☐ Inpatient Mental Health Hospital ☐ Substance Abuse ☐ Other _____
12 Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Organ ☐ Discussed Possible Future Transplant ☐ Stem Cell ☐ Transplant Complications ☐ Other _____
13 Other ☐ Yes ☐ No	☐ Condition not mentioned above with claims in excess of $5,000 ☐ Disability ☐ Congenital Disorder
14 Tobacco ☐ Yes ☐ No	☐ Anyone on this enrollment form used tobacco products in the past 12 months: Person _____
15 Medications ☐ Yes ☐ No	☐ Current Medications: Person_____# of Meds____ Person_____# of Meds____ (list meds below) ☐ Medications taken within the past 12 months: Person_____# of Meds____ Person_____# of Meds____ (list meds below

Enrollee Name: _____ SSN: _____

Please give details of all "Yes" answers above. If additional space is required, attach a separate sheet and date and sign that sheet.

Question #	Person	Condition/Diagnosis	Treatment / Meds	Physician's Name	Dates Treated	Prognosis

Signature

I authorize United Healthcare Services, Inc. and affiliates (collectively "United") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to United. I understand that the purpose of the disclosure and use of my information is to allow United to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed may be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my United representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, United also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be redisclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that United is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please maintain a copy of this authorization for your records.

Enrollee Signature: _____ Date: _____

Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or Dental Benefit Providers of Illinois, Inc.
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Employer Application for an Association Health Plan

Illinois

UnitedHealthcare®

- [x] UnitedHealthcare Insurance Company
- [ ] UnitedHealthcare Insurance Company of Illinois
- [ ] UnitedHealthcare of Illinois, Inc.
- [ ] UnitedHealthcare Insurance Company of the River Valley
- [ ] UnitedHealthcare Plan of the River Valley, Inc.

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Include a deposit check in the amount of any required payment amount. Such amount will be returned in the event coverage does not become effective and will be applied against the first month's payment amount if coverage does become effective.

Association Health Plan (AHP) Name:
AHP Tax ID:
Association type: ☐ Industry ☐ Geographic
Requested Effective Date:

General Information

Group's/Company's Legal Name

Street Address				Group Tax ID
City	State	Zip Code	Names of Owners/Partners (if applicable)	Internet Access? ☐ Yes ☐ No
Contact Person:		Email Address:		# of Years in Business:
Billing Address (if different):			Telephone:	Fax:

Multi-location group/company ☐ Yes ☐ No	# of Locations	Address (es) (or list on additional sheet of paper)
Working Owner with no common law employee, working at least 20 hours per week/80 per month ☐ Yes ☐ No		Organization Type: ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Other _____ Did you have any employees other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No

Nature of Business	Industry Code	Domestic Partner Coverage? ☐ Yes ☐ No	Medical Benefit Plan Option ☐ Calendar Year ☐ Plan Year
Names of Persons currently on COBRA/Continuation and/or Short/Long Term Disability: ☐ See Attached List ☐ None		Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Salary	

Have Workers' Comp: ☐ Yes ☐ No	Name of Workers' Compensation Carrier:	Names of Owners/Partners not covered by Workers' Compensation:

Waiting Period for new hires (Waiting period for medical coverage cannot exceed 90 days)	☐ 1st of Coverage Month following Date of Hire ☐ 1st of Coverage Month following ___ ☐ months/☐ days of employment ☐ Date of Hire (no waiting period) ☐ ____ ☐ months/☐ days of employment following Date of Hire	Waiting Period waived for initial enrollees ☐ Yes ☐ No

Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or Dental Benefit Providers of Illinois, Inc.
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Group Name _____

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
# Hours per week to be eligible _____		Dep Life		Dep Life		Dep Life		
		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
For Disability products the minimum # of work hours per week to be eligible is 30 hours.		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
		STD		STD		STD		
		STD Buy Up***		STD Buy Up***		STD Buy Up***		
***Only available to Groups with 100+ Eligible Employees		LTD		LTD		LTD		
		LTD Buy Up***		LTD Buy Up***		LTD Buy Up***		

General Information (continued)

Enter the Prior Calendar Year Average Total Number of Employees Eligible for Coverage: Include working owners if allowed by your association.

The number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly employee totals together then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees

For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year.

In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

☐ Yes ☐ No	Subject to ERISA? (Most private sector plans are ERISA plans) If No, you are not eligible for coverage.
☐ Yes ☐ No	In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
☐ Yes ☐ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
☐ Yes ☐ No	Does your group sponsor a plan that covers employees of more than one employer? If you answered Yes, then indicate which of the following most closely describes your plan: ☐ Professional Employer Organization (PEO) ☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Taft Hartley Union ☐ Governmental ☐ Church ☐ Employer Association
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group coverage. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that the AHP will not cover the co-employees under this group coverage.
☐ Yes ☐ No	Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?
☐ Yes ☐ No	Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

Group Name _____

General Information (continued)

Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

If the employee is on an employer approved leave of absence and the employer continues to pay required AHP payment amounts, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

☐ Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined on page 2).

☐ No, we do not offer medical coverage during a leave of absence.

Consumer Driven Health Plan Options

Health Savings Account (if selected): Which bank will be used: ☐ OptumBank ☐ Other

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to the coverage under the AHP?

Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No

If yes, please identify type: ☐ UnitedHealthcare HRA (any HRA design offered through UnitedHealthcare)
☐ Other Administrator HRA

HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this AHP will require you to notify UnitedHealthcare.

Current Carrier Information

Does the group currently have any coverage with United Healthcare Services, Inc. and Affiliates or has the group had any United Healthcare Services, Inc. and Affiliates coverage in the last 12 months? ☐ Yes ☐ No
If Yes, please provide policy number _____ and Coverage Begin Date___/___/___ End Date___/___/___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Initial Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			
Current Vision Carrier	☐ None			

Group Name _____

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify United Healthcare Services, Inc. and affiliates (collectively "United") promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents.

I represent the information I have provided is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that intentional misstatement or misrepresentations of a material fact, or omissions that constitute fraud, in the information requested on this form can result in the adjustment of rating or voiding of insurance.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information, or conceals information for the purpose of misleading, in an application for coverage is guilty of a crime and may be subject to fines and confinement in prison.

United disclosure regarding producer compensation:

In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we may pay "base commissions" based on factors such as product type, cost of coverage, group/company size and number of employees. These commissions, if applicable, are reflected in the cost of coverage. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the cost of coverage but are included as part of the general administrative expenses. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to your association as required by applicable federal law. For specific information about the compensation payable with respect to your particular coverage, please contact your producer.

By signing below, I attest to the accuracy, truthfulness and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in rescission of the group's Association Health Plan coverage, termination of coverage, an increase in payment amount retroactive to the coverage date, or other consequences as permitted by law.

Signature (Form must be signed)

Group/Company Signature: _____ **Date:** _____

Title:_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Producer Information (if applicable)

Producer Name	Agency	Agent Code/Tax ID Number

Email Address	Social Security #	Phone Number

All Payments to:	Producer Commission Schedule (if applicable) _____ Std Scale of _____%

Street Address	City	State	Zip Code

Producer Signature	Date

Rep Name	Rep #

General Agent Information (if applicable)

General Agent	Phone #	Franchise Code

Street Address	City	State	Zip Code

Participation & Floor Certification

[Groups with 10+ Eligible Employees]

UnitedHealthcare®

General Information	
Group's Legal Name	
Full Address	
Requested Effective Date	

Floor Calculation (AL, AR, AZ, DC, GA, IA, ID, IL, IN, KS, KY, LA, MO, MS, NC, NM, ND, OH, PA, SC, SD, TN, UT, VA, VT)		
1	Number of employees enrolling in UnitedHealthcare group medical policy	
2	Number of eligible (full time) employees	
3	Divide line 1 by line 2. This is your **floor participation percentage.**	%

Participation Calculation (AK, CA, CO, CT, DE, FL, HI, MA, MD, ME, MI, MN, MT, NE, NH, NJ, NV, NY, OK, OR, RI, SC, TX, VI, WA, WV, WI, WY)		
1	Number of eligible (full time) employees	
2	Number of eligible (full time) employees with a valid waiver reason	
3	Subtract line 2 from line 1. This is your **total eligible count.**	
4	Number of employees enrolling in UnitedHealthcare group medical policy	
5	Divide line 4 by line 3. This is your **participation percentage.**	%

Important Information

UnitedHealthcare reserves the right to review the applicant's payroll/wage & tax records at any time to confirm eligibility. UnitedHealthcare may request the applicant's most recent wage & tax payroll records. The applicant agrees to furnish UnitedHealthcare with all information and documentation which may be reasonably required with regard to eligibility for coverage.

Signature

By signing this form, I hereby certify, as a condition of eligibility, that the Group is in compliance with the minimum participation requirements as expressed in the group policy. UnitedHealthcare reserves the right to request and review payroll or other documentation confirming compliance. I represent that the information I have provided is accurate and truthful. I understand that any intentional misrepresentation of material fact or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Group Authorized Signature	Title	Date

Product and Benefit Selection Form

Restaurant and Hospitality Association Benefit Trust (RHABT)

1a. Group Name: _____

1b: Effective Date: _____

1c. Identify primary business location: _____

2a. Our firm is a member of the National Restaurant Association (NRA):
___ Yes ___ No

2b. Our firm is a member of a State Restaurant Association (SRA).
___ Yes ___ No If yes, name of SRA _____

2c. Our firm is a member of AAHOA.
___ Yes ___ No

3.

Medical Plan Code(s)	Prescription Benefit Plan Number (Rx)

4. Dental Plan Code(s)

_____

_____

5. Vision Plan Code(s)

_____

_____

Restaurant & Hospitality Association
Benefit Trust Participation Agreement

This Agreement is entered into between the Restaurant & Hospitality Benefit Trust and the Participating Employer effective _____, 20__.

Section 1: Defined Terms

"Association" means the National Restaurant Association.

"Carrier" means the insurance company that has arranged to provide and/or administer welfare benefits on a fully-insured basis with respect to Participants and Beneficiaries.

"Coverage Classification" means the type of coverage elected by Participants (e.g., single, single plus one, or family).

"Eligible Employees" refers to employees or former employees of Participating Employers who have the right to enroll in coverage under the terms of the Plan.

"Eligible Employees and their Dependents" refers to employees or former employees of Participating Employers, as well as their spouses, children and other dependents as defined under the IRC, who have the right to enroll in coverage under the terms of the Plan.

"Eligible Member" means an employer which is: (a) certified by the Association to be a dues paying member in good standing in the Association, (b) an employer of one or more employees, within the meaning of Section 3(5) and (6) of ERISA, and (c) in a trade, industry or line of business described by one the of SIC Codes listed in Section 6 of this Agreement.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Group Policy" means the group insurance policy issued by the Carrier to the Trust.

"IRC" means the Internal Revenue Code of 1986, as amended.

"NRAS" means the National Restaurant Association Solutions, which is a _____.

"Participants and Beneficiaries" are Eligible Employees and their Dependents who are enrolled in the Plan.

"Participating Employer" means an Eligible Member that has elected to participate in the Plan.

"Participation Agreement" means this document which sets forth certain rights and responsibilities of Participating Employers.

"PHI" is health information protected by applicable medical privacy law.

"PII" is information about an individual that is protected by applicable privacy law.

"Plan" means the Restaurant & Hospitality Benefit Plan, an employee welfare benefit plan under ERISA.

"Qualified Beneficiary" means a Participant or Beneficiary who qualifies for continuation coverage under state or federal law.

"Required Contribution" means the payment required of the Participating Employer under this Participation Agreement to secure coverage under the terms and conditions of the Plan.

"Service and Access Fee" means the amount payable by You to NRAS for services provided by NRAS in connection with the establishment and maintenance of the Plan.

"Trust" means the Restaurant & Hospitality Benefit Trust which holds the Group Insurance Policy.

"Trustees" means the individuals who oversee benefits under the Plan. In this document, and other plan documents, the Trustees are sometimes referred to as the Plan Sponsor.

"We," "Us," and "Our" means the Trust or its Trustees, as well as any Carrier appointed by the Trust or its Trustees to furnish welfare benefits to Participating Employers.

"You" or "Your" means the Participating Employer that has accepted this Participation Agreement.

"Your SPD" is short for Summary Plan Description and means the document describing Your benefits under the Plan.

Section 2: Your Obligations to Disclose Information About Benefits and Services

Federal employee benefits law, known as the Employee Retirement Income Security Act (ERISA), requires that a plan's covered benefits and limitations, as well the rights and responsibilities of Participants and Beneficiaries, be explained in Your SPD. By signing this Participation Agreement, You agree to distribute the SPD to Your Participants within 90 days of when they become covered under the Plan, as well as upon the occurrence of certain other events.

General Requirements for Electronic Distribution of Plan Documents. Plan documents may be distributed electronically when certain conditions are met. The following requirements apply to all recipients of electronic communications: (a) the information (e.g., PHI, PII) must be safeguarded from improper disclosure; (b) a notice (email is acceptable) informing the Participant of the significance of the document must be issued each time a document is furnished electronically; and (c) the distributor must permit the Participant to ask to receive any document in paper form.

Participants with Work-Related Computer Access. In addition to requirements (a), (b) and (c), Participants with work-related computer access must be able to access the electronic documents at any location where he or she is expected to work, and access to electronic information systems must be an integral part of the employee's job duties.

Participants without Access to Computers as Part of Work-Related Duties. In addition to (a), (b) and (c), these Participants must affirmatively consent to electronic delivery of plan information. Participants must also be provided with information about the types of documents that will be provided electronically; their right to withdraw consent; procedures for withdrawing consent and updating information (e.g., email address; the right to request paper documents; and the types of hardware and software required). Notice must be issued to the Participants alerting them to the fact that an electronic disclosure is being made. As a Participating Employer, You are required to furnish required documents in paper form (US Mail or hand delivery) if a Participant does not consent to the electronic distribution.

Upon Request. You also agree to provide Plan Participants with a copy of the SPD within 30 days of a written request. Participants should read their SPD so they understand the benefits to which they are entitled. You agree to ask Participants to keep their SPD in the same place they keep other important financial information.

Fully-Insured Plan. Because Your welfare benefits are fully insured, Your SPD will "wrap-around" or be attached to a Certificate of Coverage and Schedule of Benefits, as well as any riders and amendments, issued by the Carrier.

Changes to Your SPD. Because laws change frequently, the Carrier will periodically review Your SPD and update it to reflect any changes in the law or Your welfare plan. After the SPD has been furnished, changes may occur to the Plan or information contained in the SPD. Under ERISA, any modification in the Plan's terms that is "material"—and any change in required SPD content—must be disclosed to Plan Participants.

- When this happens, the Carrier may either issue a new SPD to You or a Summary of Material Modifications (SMM) which is a description of the change. An SMM generally will be furnished within 210 days after the end of the plan year in which a modification or change is adopted.

- If the change relates to a material reduction in covered benefits or services, the SMM will be provided by the Carrier no later than 60 days after the date of adoption of the reduction. Depending on the nature of the change, the Carrier may issue the SMM prior to the effective date of the change. You must distribute Your SMM in the same manner as the SPD explained above.

Updated SPD. You will also be required to furnish an updated SPD at least once every five years if there have been any material changes during that period of time. You will be required to furnish a new SPD once every ten years even if no material changes have been made.

Summary Annual Report. The Trustees will provide You with an annual statement summarizing the Trust's financial condition. You will be required to furnish this summary annual report within nine months of the close of the plan year.

Section 3: Required Contributions; Service and Access Fee

You are required to pay the monthly Required Contribution on behalf of Your Participants and Beneficiaries. The Required Contribution amount will be calculated based on the number of Participants and Beneficiaries that are shown in the Trust's (or the Carrier's) enrollment records at the time of calculation.

We may make retroactive adjustments to the Required Contribution for any additions or terminations of Participants or Beneficiaries or changes in coverage that are not reflected in Our records at the time We calculate the Required Contribution. Adjustments will not be made for changes occurring more than 60 days prior to the date We received notification of the change from You.

You must notify Us in writing within 31 days of the effective date of any enrollment, termination or other changes. You must also notify Us in writing each month of any change in the Coverage Classification for any Participant.

The Trust reserves the right to change the schedule of Required Contribution amounts at any time if such amount was determined based on a material misrepresentation that resulted in the rates being different than they would have been without such material misrepresentation. If this happens, We may change the rates retroactive to the effective date of Your coverage. We reserve the right to change the schedule of Required Contributions, after a 31-day prior written notice on the first anniversary of the effective date of this Participation Agreement specified in the application or on any monthly due date thereafter, or on any date the provisions of this Participation Agreement are amended.

Service and Access Fee. Each premium statement will include a separately identified Service and Access Fee. It is important that you pay the Service and Access Fee solely out of the funds that belong to your business. No Participant contributions can be used to fund the Service and Access Fee. Your participation in the Trust means that you agree to this requirement. The amount will be distributed by the Carrier directly to NRAS for services provided by in connection with the establishment and maintenance of the Plan. No part of the Service and Access Fee will be remitted to the Trust. Payment of the Service and Access Fee will be due at the same time as the Required Contribution. Participant Contributions may be used to fund the Required Contribution.

Payment of the Required Contribution and Service and Access Fee. The Required Contribution and Service and Access Fee must be paid in advance by You on a monthly basis. The first Required Contribution and Service and Access Fee is due and payable on or before the effective date of coverage. Subsequent contributions are due and payable no later than the first day of each payment period while this Participation Agreement is in force.

A charge for late payments will be assessed for any Required Contribution and Service and Access Fee not received within 10 calendar days following the due date. A service charge will be assessed for any insufficient funds check received. All Required Contributions and Service and Access Fees must be accompanied by documentation that states the names of the

Participant for whom payment is being made. In the event of a delinquency, You may be charged attorneys' fees and any other costs related to the collection of Required Contributions and Service and Access Fees.

Grace Period: A grace period of 31 days will be granted for the payment of any Required Contribution and Service and Access Fee not paid when due. During the grace period, Your coverage will continue in force. The grace period will not extend beyond the termination of this Participation Agreement. You are liable for payment of the Required Contribution and Service and Access Fee during the grace period. If We receive written notice from You to terminate the coverage during the grace period, We will adjust the Required Contribution and Service and Access Fee so that it applies only to the number of days coverage was in force during the grace period. Coverage terminates as described in Section 5 if the grace period expires and the Required Contribution and Service and Access Fee remains unpaid.

Section 4: Eligibility and Enrollment

Eligibility Rules. Minimum participation rules can be found in Section 6. Those rules are in addition to the eligibility provisions in Your SPD in the *When Coverage Begins* section of Your *Certificate of Coverage*.

Application Form: The Trust may, in its discretion, require that Your Eligible Employees complete an application form prior to enrollment in the Plan. You will be informed if this requirement applies to Your employees. When it does apply, Your Eligible Employees will not be allowed to enroll for coverage without completing the application.

Initial Enrollment Period. Eligible Employees may enroll for coverage under the Plan during an initial enrollment period preceding the effective date of this Participation Agreement.

Open Enrollment Period. An Open Enrollment Period of at least 31 days must be provided annually during which Eligible Employees may enroll for coverage under the Plan.

Special Enrollment. The Plan also provides for special enrollment opportunities upon the occurrence of certain events. Refer to Your SPD to learn more about these special enrollment opportunities.

Effective Date of Coverage. The effective date of coverage for properly enrolled Eligible Employees and their Dependents is the effective date of this Agreement.

Section 5: Termination of Coverage

Conditions for Termination of Coverage Under This Participation Agreement. This Participation Agreement and all Benefits for Covered Health Services under this Participation Agreement shall automatically terminate with respect to Participants and Beneficiaries on the earliest of the dates specified below:

- On the last day of the grace period if Your Required Contribution and Service and Access Fee remain unpaid. You remain liable for payment of the Required Contribution and Service and Access Fee for the period of time the Participation Agreement remained in force during the grace period.

- On the date We specify, after 31 days written notice to You, that this Participation Agreement shall be terminated with respect to Your coverage due to Your violation of participation and contribution rules.

- On the date We specify, in written notice to You, that this Participation Agreement shall be terminated with respect to Your coverage because You provided Us with false information material to the execution of this Participation Agreement or to the provision of coverage under this Participation Agreement. In this case, We have the right to rescind this Participation Agreement back to the effective date. Any unearned premium will be refunded.

- On the date specified by You, after at least 31 days prior written notice to Us, that Your coverage under the Participation Agreement shall be terminated.

- On the date We specify, in written notice to You, as a result of You no longer being a member of the Association.

Payment and Reimbursement Upon Termination. Upon any termination of coverage under the Plan, You are and will remain liable to Us for the payment of any and all Required Contributions and Service and Access Fees that are unpaid at the time of termination, including a pro rata portion of the Required Contribution and Service and Access Fee for any period this Participation Agreement was in force during the grace period preceding the termination.

Section 6: General Provisions

Entire Agreement. This Participation Agreement and any Amendments, Notices of Change, and Riders constitute the entire Agreement between the Trust and You. All statements made by Us, the Participating Employer, or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

Amendments and Alterations. Amendments to this Participation Agreement are effective on the date We specify. No change will be made to this Participation Agreement unless made by an Amendment which is approved by the Trustees. No agent has authority to change the Participation Agreement or to waive any of its provisions.

Relationship Between the Parties. We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Services to Covered Persons. The relationship between a network provider and any Participant or Beneficiary is that of provider and patient. The network provider is solely responsible for the services provided by it to any Participant or Beneficiary. The relationship between any

Participating Employer and any Participant and Beneficiary is that of employer and employee (or former employee), dependent, or any other category of individuals specified in this Participation Agreement. Each Participating Employer is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage).

Records. You must furnish Us with all information and proofs which We may reasonably require with regard to any matters pertaining to this Participation Agreement. We may at any reasonable time inspect:

- All documents furnished to You by any individual in connection with coverage.
- Your payroll.
- Any other records pertinent to the coverage under this Participation Agreement.

The parties agree that information and records with respect to benefits under the Plan will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, including records necessary for appropriate medical review and quality assessment or as We are required by law or regulation.

Administrative Services. The services necessary to administer the Plan and the benefits provided under it will be provided in accordance with standard administrative procedures or those standard administrative procedures of the Carrier. If You request that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, You must pay for such services or reports at the then-current charges for such services or reports.

Employee Retirement Income Security Act (ERISA). When coverage is obtained by a Participating Employer to provide benefits under an employee welfare benefit plan governed by ERISA, We will not be named as, and will not be, the plan administrator or the named fiduciary of the welfare benefit plan, as those terms are used in ERISA.

Examination of Participants and Beneficiaries. In the event of a question or dispute concerning benefits for covered health services, We may reasonably require that a physician chosen by Us examine the Participant or Beneficiary at Our expense.

Clerical Error. Clerical errors will not deprive any individual of benefits under this Participation Agreement or create a right to benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for eligible persons. Failure to report the termination of coverage will not continue the coverage for a Participant or Beneficiary beyond the date it is scheduled to terminate according to the terms of this Participation Agreement. Upon discovery of a clerical error, any necessary appropriate adjustment in premiums will be made. However, We will not grant any such adjustment in premiums or coverage to You for more than 60 days of coverage prior to the date We received notification of the clerical error.

Workers' Compensation Not Affected. Benefits provided under this Participation Agreement do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Standard Industry Classification Codes: Participating Employers must be in one of the following Standard Industry Classifications (SIC): 5812 (Eating Places), 5813 (Drinking Places), 7011 Hotels and Motels, 7032 Sporting and Recreational Camps, or 7041 Organization Hotels and Lodging Houses.

Conformity with Law. Any provision of this Participation Agreement which is or becomes in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Participation Agreement is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

Notice. When We provide written notice regarding administration of this Participation Agreement to an authorized representative of the Trust, that notice is deemed notice to all Participating Employers and their affected Participants and Beneficiaries. The Trust is responsible for giving notice to Participating Employers for the benefit of Participants and Beneficiaries on a timely basis.

Continuation Coverage. Federal and state law sometimes requires that the Trust permit certain individuals known as "Qualified Beneficiaries" to continue coverage under the Plan even in the event that they are no longer otherwise eligible for coverage. The Trust makes continuation coverage available in these circumstances through the Carrier, although You will be assessed an additional charge for this service. The circumstances under which Participants and Beneficiaries become Qualified Beneficiaries are described in Your SPD.

Written notice to Qualified Beneficiaries shall be provided by Us to the Participating Employee's last known address as contained in Your business records.

System Access. The term "systems" as used in this provision means systems that the Trust has made available, or arranged with the Carrier to make available, to Participating Employers to facilitate the transfer of information in connection with this coverage.

The Trust and its service provider(s) grant Participating Employers the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Participation Agreement. Participating Employers agree that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain property of the Trust and/or the Carrier. In order to obtain access to the systems, the Participating Employer will obtain, and be responsible for maintaining, at its own expense, the hardware, software and Internet browser requirements We provide to the Participating Employer, including any amendments to those requirements. The Participating Employer is responsible for obtaining an internet service provider or other access to the Internet.

The Participating Employer will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by Us in order to access or utilize systems, for purposes other than as expressly permitted under this Participation Agreement.

- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Participation Agreement.

The Participating Employer may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Participating Employer assumes joint responsibility for such access.

The Participating Employer will use commercially reasonable physical and software-based measures, and comply with Our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Participating Employer will notify Us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

The Trust and the Carrier reserve the right to terminate the Participating Employer's system access:

- On the date the Participating Employer fails to accept the hardware, software and browser requirements provided by Us, including any amendments to the requirements.

- Immediately on the date We reasonably determine that the Participating Employer has breached, or allowed a breach of, any applicable provision of this Participation Agreement. Upon termination of this Participation Agreement, the Participating Employer agrees to cease all use of Our systems, and We will deactivate the Participating Employer's identification numbers and passwords and access to the system.

Trust's Status. The Trust will not be deemed or construed to be the common law employer of Plan Participants and is not responsible for fulfilling any duties of an employer other than those in connection with the Plan. The Trust does not agree to assume any of Your obligations. To the extent services offered through the Trust overlap with any action You are required to perform by law, the Trust does not agree to assume Your legal duty, and You should not rely on the Trust as the primary source of information or services in order to meet its legal obligations. No statements, representations, or communications by the Trust should be construed as legal, medical or tax advice and should not be relied upon as such.

Minimum Participation Requirement. The minimum participation requirement is 75% of Eligible Employees and their Dependents, excluding valid waivers, but no less than 50% of all Eligible Employees/Dependents must be enrolled for coverage under this Participation

Agreement. For this purpose, a waiver is valid when it is for group or individual coverage that provides major medical coverage

Minimum Contribution Requirement – You must maintain a minimum contribution level of 50% of the Base Plan's Employee Only premium for each subscriber enrolled under the terms of the Plan.

Eligibility. You are responsible for establishing eligibility rules, which We will reasonably abide by, subject to any limits imposed by law or by Your SPD.

State Law. This Agreement will be governed by the laws of the State of Illinois (without regard to any conflict of law provisions).

You will be deemed to have accepted the terms of this Participation Agreement by the payment of any Required Contribution and the acceptance of coverage for Eligible Employees and their Dependents.

Participating Employer

By: _____

Date: _____

Employer Participation Certification
(Exhibit E)

Employer certifies that it meets the requirements listed below to be an employer member of the association's group health plan under section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA). It understands that it must be a member of the association in good standing to be eligible to participate in the plan.

Employer further understands that status as an employer member, by itself, is not a guarantee of coverage and does not confer upon it the right to participate in the association's group health plan, which is governed by the by-laws of the association and applicable law, including regulations issued under ERISA. Finally, such by-laws and applicable law are subject to change.

I certify that each of the following requirements has been met:

1. Employer certifies that it is a member in good standing of the association and is eligible to participate in the association's group health plan.

   Employer Address: _____ Association Name: _____

   _____ Association Address: _____

   Employer EIN: _____ _____

2. Employer is: (a) in the same trade, industry, line of business or profession as other employers that are members of the association; or (b) has a principal place of business in the same region that does not exceed the boundaries of a single State or a metropolitan area (even if the metropolitan area includes more than one State).

   If applicable, association's geographic region is: N/A

3. I agree to notify the carrier in the event any factual information that provided the basis for this certification changed or was subsequently determined to not be accurate and understand that the issuer is required by law to monitor compliance with these requirements.

4. I agree to provide the issuer with documentation to verify the accuracy of the information being certified upon request.

5. Check one of the boxes below:

   [ ] Employer acts directly as an employer of at least one non-spouse employee who is or will be a participant covered under the plan, or

   [ ] Employer is a Working Owner permitted by the by-laws of the association to participate in the plan with: (i) an ownership right in a trade of business, incorporated or not, including a partner or other self-employed individual; (ii) who either:

   (A) works on average at least 20 hours per week or at least 80 hours per month providing services to the working owner's trade or business, or

   (B) has wages or self-employment income from such trade or business that at least equals the working owner's cost of coverage for participation by the working owner and any covered beneficiaries in the group health plan sponsored by the association in which the individual is participating.

By signing below, I attest to the accuracy, truthfulness and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in a loss or termination of coverage under the association plan, an increase in the Required Contribution (Payment Amount), or other consequences as permitted by law.

Employer Member

By: _____ Title: _____

Print Name: _____ Effective Date: _____

COBRA Addendum to the Employer Participation Agreement

Employer Member acknowledges that the Association Health Plan (AHP) providing its employees with group health plan coverage may be subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer Member agrees that it will promptly notify the COBRA administrator of any COBRA qualifying event that will cause a covered employee, dependent or child to lose health coverage.

In the event that Employer Member fails to provide notice to the COBRA administrator, it agrees to indemnify and hold the AHP harmless against any and all loses, liabilities, penalties, fines, costs, damages, and attorney fees, including the costs of litigation, that may result from a failure to provide of a qualifying event to the COBRA Administrator.

COBRA administrator cannot be responsible for continuation of coverage services in the event that the Employer Member obtains ancillary health benefits (such as dental, vision) outside of the AHP.

Any provision of this COBRA Addendum which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the AHP is administered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

Employer Member

By: _____

Print Name: _____

Title: _____

Effective Date: _____

Information about COBRA, including a list of qualifying events, can be found at the link below:

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf

Getting your non-resident insurance license in Illinois

The Restaurant and Hospitality Association Benefit Trust is filed with the state of Illinois; therefore, the large employer group is situs in Illinois.

Illinois NON-RESIDENT Insurance License Requirement:

All agents must be appointed in Illinois to receive commission on Restaurant and Hospitality Association Benefit Trust business.

If commission is paid directly to the Agent:

If commission is paid directly to the agent, then only the writing agent will be required to have a non-resident license in the state of Illinois to receive commission on Restaurant and Hospitality Association Benefit Trust business.

If commission is paid to the Agency:

If commission is paid directly to the agency, then both the writing agent and agency are required to have a non-resident license in the state of Illinois to receive commission on Restaurant and Hospitality Association Benefit Trust business.

How to get a non-resident license in Illinois?

Apply online: https://pdb.nipr.com/my-nipr/frontend/identify-licensee

Submitting your non-resident license to UnitedHealthcare for processing:

Send the following to: appointment_credentialing@uhc.com
Name & Producer number
Attach: Non-Resident insurance license (actual certificate)

Employer eServices Scheduled Direct Debit

Sign up for UnitedHealthcare Scheduled Direct Debit to automatically deduct your premium payments from your bank account.

Streamline your monthly invoice payment process.

Scheduled Direct Debit from Employer eServices® is a convenient way to pay your monthly insurance premiums.

After you sign up, your premium will be automatically deducted from your company's bank account.

Even better, Scheduled Direct Debit helps you streamline your monthly invoice payment process and better organize your payment records, which frees you up to focus on the business of your business.

Enroll today and worry about one less thing tomorrow.

Enrollment instructions:

1. Complete the Scheduled Direct Debit Authorization Form on the back of this page.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.
3. Return the completed form by fax, mail or email. Contact information is listed on the form.

IMPORTANT: Please return the completed form along with a voided check (no deposit slips, please) or an authorized bank letter.

CONTINUED

With Scheduled Direct Debit, everything is taken care of—automatically—which means you can:

- Pay your premium at the same time, on time, each month.
- Maintain a consistent process for your payments.
- Better predict cash outflow.
- Access an accurate record of your payments, which are listed on your bank statement.

UnitedHealthcare®

Scheduled Direct Debit Authorization Form

Authorized signature and title of signatory

Date

Employer name/Customer name/Policy name

Employer email address

UnitedHealthcare customer number

UnitedHealthcare bill group(s)

Name of your financial institution

Telephone number of financial institution

Routing/Transit number (9 digits)	Account number (include all zeros and omit spaces/special characters)

IMPORTANT: Please return the completed form along with a voided check (no deposit slips, please) or an authorized bank letter.

Mail to: UnitedHealthcare – Duluth
Attn: Accounts Receivable
MN 015-2838
4316 Rice Lake Rd.
Duluth, MN 55811

Fax to: 1-888-476-5127
Attn: Accounts Receivable

Email to: Direct_Debit@uhc.com

Statement of understanding

This agreement is made in accordance with the operating rules and regulations of the National Automated Clearinghouse Association. By executing this document in the space provided above, I confirm that I am authorized to act on behalf of the employer/customer ("Group") and agree on behalf of the Group to the following terms and conditions:

- **By choosing Scheduled Direct Debit, the customer understands all invoicing will be online only located at www.employereservices.com. Should there be any questions pertaining to accessing and/or location of the invoice, please call 1-800-651-5465.**
- Group authorizes UnitedHealthcare to debit the group checking or savings (account number provided above) for all monthly charges for coverage.
- Group understands that it may take up to one month to set up Scheduled Direct Debit and consequently all overdue premiums should be promptly paid in order to avoid receiving a delinquency letter and possible termination of your account during this initial set up period.
- Group understands and agrees that it will have sufficient funds in its account to cover the full premium invoice on the draft due date. If necessary funds are not in your account on the draft due date, group coverage may be subject to termination proceedings consistent with the terms stated in your UnitedHealthcare contract.
- Group understands that the amount drafted may vary based on billing premium adjustments reflected on your monthly invoice.
- Group understands UnitedHealthcare may make adjustments to the account whenever a correction or change is required. For example, if there is an error, the group/member agrees that UnitedHealthcare may correct the error immediately and without notice. Such errors may include, but are not limited to, reversing an improper credit, making adjustments for returned premium, and correcting calculation and input errors. The right to make adjustments are not subject to any limitations or time constraints, except required by law.
- Payment will be withdrawn on the date indicated on your monthly invoice.
- Group agrees to promptly notify UnitedHealthcare of any change to the information provided.

Authorization

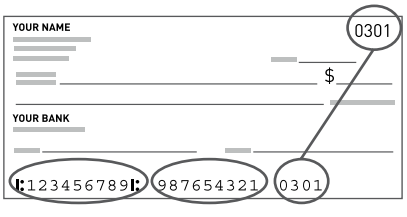
Authorization is given to UnitedHealthcare to initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to UnitedHealthcare; it is canceled by UnitedHealthcare under the conditions stated above; or upon termination of coverage with UnitedHealthcare.

Signature required _____

Determining your routing number

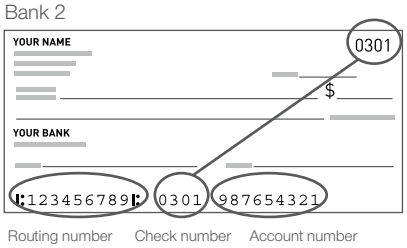
To determine your routing number, refer to your company check. The routing number is always 9 digits long and it is enclosed by colons. The location of the routing number and account number on your company check varies depending on your bank.
For example:

Bank 1



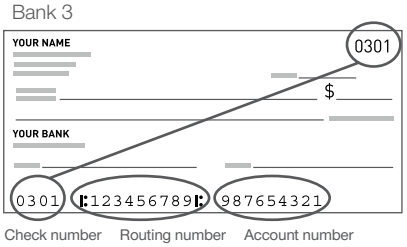
Routing number Account Number Check number

Bank 2



Routing number Check number Account number

Bank 3



Check number Routing number Account number

Please contact your financial institutions if you have any questions about your routing number or account number.

UnitedHealthcare®