

Medical Expense Reimbursement Plan Application/Adoption Agreement



Administered by:
Significa Benefit Services, Inc.
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Trust No: _____
Group No: _____

Broker/Agency: _____

It is the intention of the employer named in this Application/Agreement to adopt the self-funded Internal Revenue Code Section 105 (h) Medical Expense Reimbursement Plan (Plan) described below:

Type(s) of Reimbursement:

Medical (attach copy of benefit outline) **Other** (specify) _____
Dental (attach plan design) _____
Vision (attach plan design) _____

Funding Method: MICR (Additional Fee) ACH Processing

Maximum amount(s) the Plan will reimburse participating employees:

For Medical Expenses – Deductible Only

Note: all In-Network and Out-of-Network Deductibles will be applied until the Maximum Medical Reimbursement Benefit is exhausted*

Employee responsibility =
\$ _____ of the family annual deductible

***Employer reimbursement =**
\$ _____ of the family annual deductible

Employee responsibility =
\$ _____ of the family annual deductible

***Employer reimbursement =**
\$ _____ of the family annual deductible

For Dental Expenses

\$ _____ per Family per Calendar Year

\$ _____ per Family per Calendar Year

For Vision Expenses

\$ _____ per Family per Calendar Year

\$ _____ per Family per Calendar Year

Will EGA be crediting deductibles from a previous medical plan? Yes No

If Yes, EOBs from the medical plan must include year to date deductible amounts.

Reimbursement Guidelines – Always Pay Provider ____ Always Pay Employee ____ At Employee's Discretion ____
If provider reimbursement is requested, a copy of the itemized bill must be included with the EOB.

Automatic Claim Crossover? (Limited to groups with medical coverage through SBS or Significa) Yes No

Employer must attach a copy of the requested plan design with the application. Benefits will be adjudicated in accordance with this documentation. Include information such as whether the benefits apply to in or out of network, if reimbursing co-payments, list which type, and indicate if the employee must meet a portion of deductible/coinsurance or some other benefit out of pocket before benefit reimbursement.

Benefit Period: _____ Calendar Year _____ Plan Year

Eligibility:

Same as Group Health Plan Other (specify) _____ Number of Eligible Employees: _____
Maximum Age Limit for Child Dependent: _____ Maximum Age Limit for Student: _____

Employer/Plan Sponsor Information:

Company Name: _____ Requested Effective Date: _____

Street Address: _____

Mailing Address: _____

Company Type: Sole Proprietor Partnership C Corporation S Corporation **SIC Code:** _____

(Note: the "self-employed", including 2% or greater shareholders in an S Corporation cannot receive tax-free reimbursements from a MERP)

Contact: _____ Telephone: _____ Fax: _____

EIN Number: _____ Name of Medical Carrier: _____ (Attach benefit outline)

The Employer hereby adopts the Plan. In doing so, the Employer understands and agrees to the following: 1) the Internal Revenue Service requires a legal plan document for a Medical Expense Reimbursement Plan and the Employer will comply with the provisions of the plan document; 2) there must be a plan in place for employees' reimbursements to be nontaxable; 3) if the Plan discriminates in favor of "highly compensated" individuals, these people could be taxed on all or part of their reimbursements; 4) the Plan must be made clear to eligible employees, plan participants, and beneficiaries, each of whom must receive a Summary Plan Description; 5) there are additional tax and legal implications for this type of medical reimbursement plan which should be reviewed with the Employer's financial and legal counsel; 6) this Application/Agreement is not an insurance contract and the Employer is responsible for funding an amount equal to the actual claims paid, as well as paying an administrative fee; and 7) MERP is subject to COBRA if applicable.

Authorized Signature: (Employer) _____

Date: _____