TRIAD
BENEFITS

Health Plan Participation

Request/Contract

Section 1 Member Information

Member Name_____

SS# or Federal Tax ID Number_____

Address_____ Phone #_____

City, State, Zip Code_____ Fax #_____

Email Address_____

Participating Association_____ Broker Name_____

Section 2 Billing Information *(If Different from Above)*

Billing Address_____ Phone #_____

City, State, Zip Code_____ Fax #_____

Billing Contact Name_____

Section 3 Billing & Collections Guidelines

Initial Contract for the Member, as stated in Section One (1) and incorporated herein by reference, shall remain in force for twelve months from the Effective Date of Coverage ("Effective Date") unless terminated pursuant to the terms and conditions contained herein. Unless otherwise agreed to in writing by Triad Benefits, LLC. ("Plan"), the Effective Date shall always be the first day of the month. Any subsequent Contracts for Renewal of Coverage ("Renewal Contracts") shall remain in force for subsequent periods of twelve (12) months unless terminated by the Member or the Plan. Payment of money to cover the cost of Health Benefits ("Healthcare Fees") shall be remitted to the Plan monthly, subject to the following guidelines for Billing and Collections:

1 Billing shall be based on the current census of members and dependents that are on record with the Plan, as of the date on which invoices are generated. Member understands that any changes to their census may result in changes to their healthcare fees.

2 On approximately the 5th of each month, you will receive your invoice via email. Payment is due the 15th of each month and considered late if not paid by the 30th of the month, at which time the group will be subject to termination if not paid in full.

3 Unless notified otherwise by the Plan, monthly healthcare fees shall be drafted via Automated Clearing House ("ACH") on, or around, the 15th business day of each month from a bank account designated by the Member for purposes of pulling healthcare fees. If insufficient monies are available in the account, the Member shall experience a suspension in the payment of claims. Said suspension shall continue until the Member's designated account has enough monies to correct the delinquency, at which point the Member's account can be considered current.

4 Member agrees to reimburse the Plan for any claims incurred and or paid during any period of delinquency, including, but not limited to, additional expenses that may be assessed due to late and or non-payment.

5 Any Member that fails to remit healthcare fees by the 30th day of the then-current month shall be terminated from the Plan. If payment of healthcare fees is received within the original due date ("Grace Period"), then the Member's participation in the Plan may be reinstated, without a break in coverage. All reinstatements are subject to review, potential rerate and/or declination.

6 Member understands and agrees that the Plan may modify health care fees based on Member's experience, utilization and/or demographic change..

7 At the Plan's discretion, any Member that is terminated from the Plan for non-payment of healthcare fees may resume participation in the Plan once all outstanding healthcare fess are paid in full, if reinstatement has been approved.

8 Member and dependent terminations must be sent to the Master General Agent ("MGA") or TPA using the appropriate form(s) at least fifteen (15) days ("Minimum Notice") prior to the requested date of termination. Member understands that any failure to provide this Minimum Notice will result in a termination delay, which will be no less than thirty (30) days. Member understands and agrees to remain liable for payment of healthcare fees for those experiencing a termination delay.

By signing this Request/Contract in Section Twelve (13), the Member agrees to the "Billing and Collection Guidelines," as described herein, and understands that failure to do so shall result in the termination of this Request/Contract. Furthermore, the Member understands and agrees they shall remain liable for the healthcare fees due to the Plan, even if this Request/Contract is terminated by the Plan for non-payment of healthcare fees.

Section 4 Requested Effective Date

Requested Effective Date: _____,20___

Member: In the space above, please indicate the month in which you would like for coverage from the Plan to begin. This date is a non-binding request that is contingent upon receipt of all quoting/enrollment materials and subject to the Plan's acceptance of this Request/Contract. Once accepted, the Member will provide notification of your actual Effective Date, which shall only be on the first day of any given month.

Section 5 Plan Type & Member Coverage

Member hereby requests participation as indicated on the Member's Plan Selection, as shown in Section Twelve (12), which is incorporated herein by reference.

Section 6 Healthcare Fees and Contract Terms

Members seeking first-time coverage from the Plan ("New Groups") agree that healthcare fees assessed pursuant to Initial Contracts shall remain in force for 12-months from the effective date unless otherwise modified by the Plan. New Groups shall be construed to include any Member that had previously lost coverage from the Plan as the result of any failure to remit payment of healthcare fees before the end of the Grace Period.

Upon conclusion of an Initial Contract, Members may continue their coverage with the Plan for subsequent periods that are no less than twelve (12) months. Unless otherwise modified by the Plan, healthcare fee amounts assessed pursuant to Renewal Contracts remain valid from effective date of coverage for 12-months or the terms of their contract. Members that remit payment for healthcare fees as due on the Renewal Date will be deemed to have accepted the Renewal Contract. Unless otherwise notified by the Plan, Members understand and agree that the terms and conditions of Renewal Contracts are the same as those in effect for the Initial Contract. Members agree the Plan reserves the right to adjust healthcare fees during Initial and or Renewal Contracts if the claims expense and or Plan utilization exceeds projections.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, agrees to all the terms and conditions contained herein.

Section 7 Termination of Contract

Member may terminate this Request/Contract upon renewal.

Member agrees that the Plan reserves the right to modify, terminate, or rescind this Request/Contract back to the original Effective Date if any member intentionally provides the Plan with inaccurate information about their health or the health of their dependents during the underwriting process. Rescind means that the coverage was never in effect. Should this Request/Contract be rescinded, the Member agrees to accept liability for all claims that have been incurred by their members or dependents of their members but not paid.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, agrees to all the terms and conditions contained herein.

Section 8 Summary of Benefits and Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to compare options and select health plans easily. Members can access SBC's by visiting www.acuity-grp.com . A hard copy of the SBC can also be provided upon request. Please call Acuity at (866) 872-6356 for a copy. For more information regarding this health care reform provision, please visit www.healthcare.gov.

Section 9 Underwriting Guidelines

Underwriting Guidelines, as established by the Plan, shall be enforced while all Initial and Renewal Contracts are in force and shall continue to do so unless the Member is notified otherwise by the Plan.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, agrees to be bound by the Plan's Underwriting Guidelines.

Section 10 Conditions of Participation

The Plan shall exclude coverage for work-related sickness or injury eligible for benefits under workers' compensation, liability, Own Occupation, Occupational Accident, or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, liability or similar State or Federal law and does not have such coverage. Proof of waiver of coverage will be required for those members eligible who waived or not enroll based on the State and/or Federal law.

Current workers compensation provider: _____

Policy # and phone number: _____

Current excluded members: _____

_____

Section 11 Conditions of Participation

Member further agrees that:

1 For coverage to go into effect, the Member's Request/Contract must be accepted by the Plan.

2 For coverage by the Plan to remain in force, the Member must: (1) be an eligible member of Triad Benefits, LLC when applying for participation in this Plan; (2) meet plan membership requirements established by the governing documents of Triad Benefits, LLC, including working full time (defined as working 30- hours or more per week), the plan reserves the right to request wage and tax as verification and under 65 years of age; (3) remain a willing member in good standing of Triad Benefits, LLC.

3 The Member has seen a copy of the benefits proposed and agrees to remit all applicable healthcare fees to the Plan as outlined in Section Three (3). Member further agrees to allow all eligible members an opportunity to enroll for coverage.

4 The member/group understands that even after their group health applications have been rated and approved, it is the members responsibility to notify the plan of any health changes prior to the approved effective date. Failure to do so could be considered a misrepresentation of health facts and result in coverage and any claims incurred being denied or rescinded. This is at the sole discretion of the plan

5 At all times, the coverage is subject to the benefit plan applied for by the Member, which alone constitutes the Contract under which benefits become payable.

6 By signing this Request/Contract, Member understands that the Member has joined Triad Benefits, LLC which is the Plan Sponsor, and the Member is entitled to exercise rights to receive all products and services offered by Triad Benefits, LLC to Members.

7 Member understands and agrees that the Plan may not renew health care coverage which determination is left to the sole discretion of the Plan.

8 Member agrees that the Plan shall not be liable for any health care claims incurred by any Member(s) and or Dependent(s) after the date on which coverage was terminated. Member agrees to reimburse the Plan for covered charges which were incurred by any Member(s) and or Dependents(s) after the date on which coverage was terminated.

Acceptance of this Request/Contract by the Plan is subject to the Member's willingness to be bound by the Plan's requirements. For purposes of this Section, these requirements include the provisions of any Administrative Services Agreement between the Plan and its TPA, but only to the extent, such provisions apply to rights and or obligations of Members that participate in the Plan.

By signing this Request/Contract in Section Thirteen (13), the Member, as stated in Section One (1) and incorporated herein by reference, hereby requests participation in the Plan and agrees to be bound by all the terms and conditions contained herein.

Section 12 Member Plan Selection

INSTRUCTIONS:
STEP 1: Select your Medical Plan Option - You can select one plan, or any combination of the multiple medical plan options offered.

STEP 2: Member Selection - Send a signed identifying census which plans and what tier (e.g., family, EE, etc.) currently covered members are choosing. Otherwise, plan implementation cannot move forward, and you will experience a delay.

Note: Please ensure you fully understand the Plan Benefits you are enrolling in, as you can only change your selections during the Plans Open Enrollment.

Medical Plan Options Check your selected plan(s)

☐	Plan #1 $1,000 Individual deductible	$2,000 Family Deductible
☐	Plan #2 $1,500 Individual Deductible	$3,000 Family Deductible
☐	Plan #3 $2,500 Individual Deductible	$5,000 Family Deductible
☐	Plan #4 $3,500 Individual Deductible	$7,000 Family Deductible
☐	Plan #5 $5,000 Individual Deductible	$10,000 Family Deductible
☐	Plan #6 $7,350 Individual Deductible	$14,700 Family Deductible
☐	Plan #7 $3,500 HSA - $3,500 Individual Deductible	$7,000 Family Deductible
☐	Plan #8 5,000 HSA - $5,000 Individual Deductible	$10,000 Family Deductible

Waiting Period – 1st of the Month following 30 days of employment

Network Selected

RBP ☐ Cigna ☐

Section 13 Member Attestation and Signature

Member hereby acknowledges and understands that (1) all enrolled members must meet all the Plan's terms and conditions, outlined herein; (2) waivers must be provided for all members waiving coverage; and (3) absent a Qualifying Life Event, as defined in 26 CFR 1.125-4, members and any of their respective dependents are not permitted to make changes until the next open enrollment period, as established by the Plan.

Member takes full responsibility that the information provided to the Plan by its members and any of their respective dependents is accurate. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime.

Authorized Representative of Member (Name)

Authorized Representative's Signature Date

Broker Representative: