Members HealthPlan NJ

Designed for You.

HEALTH PLAN PARTICIPATION REQUEST / CONTRACT

Please Print

Please send forms to:
Concord Management Resources
P.O. Box 5487
Somerset, NJ 08875
Phone: 833-MEWANOW (833-639-2669)
Fax: 833-MEWAFAX (833-639-2329)
Email: mewaenrollment@concordmgt.com

Section 1: Employer Information

Employer Name: _____

To be completed by Trust (Plan Sponsor)
Eligibility **Group #** **Account #**

Federal Tax Identification #: _____

Address: _____
Street Address Suite City State Zip

Phone: ( )_____ Fax: ( )_____ E-Mail Address: _____

Affiliation(s) (If Applicable): _____ Specialty or Business Type: _____

Section 2: Billing Information

Billing Address (if different from above): Phone: ( )_____ Fax: ( ) _____

_____
Street Address Suite City State Zip

Billing Contact Name: _____

Method of Payment (Check One):

☐ Direct Debit from Bank Account
Please attach a copy of a voided check.

Bank Name: _____

ABA Routing #:_____ Account #: _____

☐ Check Remittance

Section 3: Billing & Collections Guidelines

Although the contract period is one year (except as provided in Section 7), payment of the Health Care Fee will be required monthly. The following guidelines will be used for the Billing and Collection of the Health Care Fee:

1. *Bills will be available by the 15th of the month prior to the billing month.*
2. *If paying by check – the remittance will be due on the 1st of every month.*
3. *If paying by Direct Debit – the payment will be deducted on the 1st business day of every month.*
4. *If payment is not received, or moneys are not available for debit from a bank account by the end of the 31-day grace period, all coverage for a Participating Member/Group's covered employees may be terminated retroactive back to the 1st of the month for which payment was due and the Participating Member/Group will be responsible for Health Care Fees due until the earlier of the end of the contract period or by providing the Trust with the proper termination notice as provided for in Section 6.*
5. *Reinstatement will not be permissible for a Participating Member/Group until the next Annual Open Enrollment Period.*
6. *Employee and/or dependent terminations must be sent to the Plan Administrator prior to the termination date. If a termination request is received more than 15 days after the termination date, the employee and/or dependent will not be terminated until the end of the month in which the termination is received and the employer will be responsible for any applicable Health Care Fees. Employers are ultimately responsible for confirming terminations are received by the Plan and should review their bills each month.*
7. *Billing will be based on the current census of employees enrolled in our system. Upon enrollment if quoted membership changes more than 10% from the original quote or if the group's membership changes more than 10% during the year, the Plan reserves the right to requote. The rate structure is subject to change at any time.*

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

Section 4: Effective Date of Coverage

Effective Date of Coverage:_____.

Please note the date that the applicant wishes coverage to start for eligible employees. This date is contingent upon acceptance of this Participation Request/Contract by the Trust. The applicant will be notified of the acceptance of this request and effective date in writing.

Section 5: Plan Type & Employee Coverage

The applicant requests participation for the following coverage: ☐ **Medical/Rx Only** ☐ **Medical/Rx & Dental**

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

Section 6: Health Care Fees

Exhibit A - **Health Care Fees (rates)** - effective from the Effective Date of Coverage above through_____(Initial Contract Period). In addition to changes in rates based on employee ages, rates may be adjusted during the contract period should the claim expense and/or plan utilization exceed projections.

Section 7: Contract Terms & Termination of Contract

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

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

By signing this contract, the applicant agrees to pay the Health Care Fees (Exhibit A) as provided in Section 6, based on the census maintained by the Trustees for employees that are eligible for coverage under the benefit plan applied for through the end of the Initial Contract Period and, upon payment of revised Health Care Fees, any Renewal Contract Period. The applicant understands that each Renewal Contract Period will be for additional periods of twelve (12) months and at the Health Care Fees provided by the Trust 30 days prior to the end of each contract period, subject to change as described above.

Section 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 easily compare options and select health plans. Members can access SBC's by visiting www.membershealthplannj.com/forms-documents. A hard copy of the SBC can also be provided upon request, please call the Plan at the phone number listed on the back of your ID Card for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit www.healthcare.gov

Section 9: Underwriting Guidelines

Exhibit B - Underwriting Guidelines are in force from the Effective Date of this contract and remain in effect for each subsequent Renewal Contract Period unless written notification is provided by the Trust.

By signing this contract, the applicant agrees to the attached (Exhibit B) underwriting guidelines and understands that should it provide false information or fail to meet the requirements for eligibility that it will result in the termination of this contract for all covered persons.

Section 10: Statement of Contingent Liability

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

Section 11: Participation Request

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

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

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

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

Name of Applicant (Please Print): _____

Signed:_____ **Date**: _____

Section 12: To be filled out by Trust (Plan Sponsor)

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

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

Signed: _____ **Date**: _____

Authorized Representative of the Trust