State of Idaho

DEPARTMENT OF INSURANCE

C.L. "BUTCH" OTTER
Governor

700 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043
Phone (208) 334-4250
FAX # (208) 334-4298

DEAN L. CAMERON
Director

EXHIBIT A DATE:_____

APPLICATION FOR REGISTRATION OF SELF-FUNDED HEALTH CARE PLAN

_____

(Type of Plan: Single Employer Plan, or Multiple Employer Welfare Plan, or Postsecondary Educational Institution Student Health Benefit Plan)

_____

(Name of Trust Fund)

_____

(Address of Principal Office of Fund) (Phone No.)

Effective date of the Plan:_____

To the Director of Insurance of the State of Idaho:

STATE OF)
COUNTY OF) ss
)

_____ , Employer(s) / Postsecondary Educational Institution and

_____ , Trustee, being duly sworn each for himself deposes and says that the information contained in this Application for Registration is true to the best of his knowledge and belief.

_____
Employer(s) / Postsecondary Educational Institution

_____
Trustee

Subscribed and sworn to before me this

_____day of _____, 20_____

_____

My Commission Expires: _____

REGISTRATION

GENERAL INTERROGATORIES

1. Is this Plan maintained for the purpose of complying with any workers' compensation law or unemployment compensation disability insurance law?

   _____

2. Is this Plan administered by or for the Federal Government of agency thereof?

   _____

3. Is this Plan primarily for the purpose of providing first aid care and treatment, at a dispensary of the employer / postsecondary educational institution, for injury or sickness of employees / students while engaged in their employment / education?

   _____

   (If yes, describe)

4. Provide date the Plan began operation, if already in existence. _____

5. Provide the Fiscal Year-End date for the Plan's Financial Statement Reporting. _____

6. Is this a self-funded plan established for the sole purpose of funding the dollar amount of a deductible clause contained in the provisions of an insurance contract issued by an insurer duly authorized to transact disability insurance in this state?_____

   If the answer is yes, please provide the following information:

   Deductible amount per person _____

   Number of deductibles per family _____

   Number of Beneficiaries Insured _____

   Total aggregate amount of all deductible obligations_____

7. Give the name(s) and address(es) of the employer(s) / postsecondary educational institution for whose employee-beneficiaries / students the trust fund is operated. _____

   _____

   _____

   _____

   _____

8. Provide the name and address of the administrator of the Plan.

_____

_____

_____

9. Provide the names and addresses of the trustees of the Plan.

_____

_____

_____

10. Provide the names and addresses of Plan consultants, if any.

_____

_____

_____

11. Provide the names and addresses of insurance agents or brokers transacting business with the Plan, if any.

_____

_____

_____

12. Provide the names and addresses of associated or affiliated trust funds and/or Plans under control of management of the administrator or trustees named herein.

_____

_____

_____

13. If benefits are provided by any means other than direct payments of a trust fund, or from a TPA on behalf of trust fund, please complete the following schedule and attach a copy of the group policy and/or other contract covering these benefits:

GENERAL DESCRIPTION OF BENEFIT	NAME & ADDRESS OF PERSON PROVIDING BENEFITS

14. Are all contributions to the Fund payable in advance?

    _____

15. Does the Plan operate under the provisions of a Trust Agreement between the employer(s) / postsecondary educational institution and the Trustee? _____

16. Have guidelines been established for trustees of the Plan? _____

17. Have guidelines been established for administrators of the Plan?_____

18. If the Plan is already in operation, has each employee-beneficiary / student received, and will each future employee-beneficiary / student receive, a written statement or schedule adequately and clearly stating all benefits allowable under the Plan, together with all applicable restrictions, limitations and exclusions, and the procedure for filing a claim for benefits? _____

19. If the Plan is not yet in operation, will each employee-beneficiary / student receive a written statement or schedule as described in 18 above? _____

20. How often are the trust funds audited by an independent accountant?_____

    Name and address of auditing firm: _____

    _____

21. (a) Have the trustees, officers and all individuals that will handle receipts and disbursements for the Trust Fund been bonded under a fidelity bond issued by a surety authorized to transact such surety business in the State of Idaho?_____

    If so, give name and address of Surety _____

    _____

    and amount of fidelity coverage: _____

    If a TPA is utilized, have they been bonded for an amount in compliance with Idaho Code §41-911? _____

    (b) Are individuals handling receipts and disbursement for the Trust Fund licensed as an administrator per Idaho Code Chapter 9, Title 41?_____

22. Do you assert that this plan's program of coverage is qualified under the Employee Retirement Income Security Act (ERISA)? _____

    If so, attach a copy of notice of this qualification from the United States Department of Labor.

23. Please complete the attached chart on page 6.

Benefits Checked Are Provided:					Contributions Are Made By:		Approximate Number of Beneficiaries Covered	
Benefit	Directly Out of Trust Fund Including Those Administered By TPA	By Insurance Carrier(s)	By Hospital and Medical Service Plans	Other (Specify)	Employer / Postsecondary Educational Institution	Employee / Student Payroll Deduction	Employee / Student	Covered Dependents
Disability Income								
Hospital								
Medical								
Surgical								
Dental								
Vision Services								
Other (Specify)								