# Simple Case Approval Process

Simply Business[SM]

## GET READY...

Submit the following Simply Business[SM] case information forms in this booklet (also downloadable from the Agent Web site) to your MedAmerica sales specialist.

- Application for Employer Program Offering Form (SE2-100 - see opposite page)
- Employer Census (see requirements below)
  Simply use your agent user name and password (as used when logging into the MedAmerica Agent Web site) to securely upload the electronic census to https://www.yourlongtermcare.com/groups/DocUploadStart.do
  You may also fax or mail a paper census to MedAmerica.
  Don't have an electronic census? No problem! Simply complete the Census Worksheet (for group sizes 3-49 only) on page 11 (SE2-101) and your MedAmerica sales specialist will create one for you!
- Employee Education & Enrollment Plan (SE2-102 - see page 13) - Required for employer-funded cases and voluntary groups of 50+ only
- Agent Worksheet (SE2-103 - see page 15)

Mail materials to the attention of your sales specialist at MedAmerica Insurance Company, 165 Court Street, Rochester, NY 14647, fax to 585-238-3693, or simply use the link above to quickly and securely upload all of the required documents.

## GET SET...

Your sales specialist will call you to discuss the case and confirm the information submitted.

- If payroll deduction is requested as the billing option, the sales specialist will work with you to coordinate a payroll conference call with the employer. At this time, you should also submit the completed and signed Payroll Deduction Questionnaire (SE2-104) located on page 17.
- Payroll conference calls are required for payroll deduction. After the call, your MedAmerica sales specialist will confirm the information for setting up the billing and request the employer's confirmation. Please note, these steps must be completed before MedAmerica can approve the case and assign a case number.

## GO!

Approval Notification—And You're Ready to Write!

You will receive an e-mail approval along with a copy of the Employer Notification Letter. Copies of the Simply Business[SM] forms the employer submitted will also be sent for the employer's records. (See samples on pages 21 and 22) At this time, you should order your forms and marketing materials.

### Census Requirements

- Employee's first & last name
- Date of birth
- Employment status — Indicate (F) full-time or (P) part-time
- Status type — Indicate employee, retiree, or board member
- State of residence
- Employer Funded — Indicate (1) Full Benefits; (2) Defined Benefit; or (3) Dollar Contribution
  Note: Employer-funded field is only required if the employer is paying 100% of a defined benefit or a defined contribution for select employees.
- Date of hire (Not required on initial census, but is required for any updated census.)

# MedAmerica Simply Business℠
# Application for Employer Program Offering

## 1. Employer Information

| | |
|---|---|
| Company Name | Employer Contact Name and Title |
| Address, City, State, Zip Code | Company Web site |

| | ( ) | ( ) |
|---|---|---|
| Contact E-mail Address | Telephone | Fax |

Type of Company (Check one box) ❑ Government ❑ Non-Profit Organization ❑ Privately Held ❑ Publicly Traded

Type of Industry (i.e. Hospital, Manufacturing, Engineering)

| # of W-2 Employees working 30 hours or more per week | | # of W-2 Employees working LESS than 30 hours per week | | Enter # of Eligible Board Members | | Enter # of new employees in last year | |
|---|---|---|---|---|---|---|---|

Do you have employees in more than one state? ❑ Yes* ❑ No

* If Yes, list all states where you have employees ❑ All 50 States OR Please List:

## 2. Employer Funding: NOTE - When Only Select Eligibles Are Paid: We default all other Employees to a Voluntary Offering.
If choosing more than one option, be sure the Census correctly indicates who falls into the various choices.

1. ❑ Employer pays 100% of ALL BENEFITS CHOSEN for: ❑ All Employees ❑ All Care Partners
Must identify individuals on the Census supplied with this form. ❑ Select Employees Only ❑ Care Partners of Select Employees
Billing Frequency (Choose One) ❑ Monthly ❑ Annual | Pay By (Choose One) ❑ Check ❑ Wire

2. ❑ Employer pays 100% of DEFINED BENEFIT for: ❑ All Employees ❑ All Care Partners
Must identify individuals on the Census supplied and Illustration of proposed plan. BOTH must accompany this form. ❑ Select Employees Only ❑ Care Partners of Select Employees
Billing Frequency (Choose One) ❑ Monthly ❑ Annual | Pay By (Choose One) ❑ Check ❑ Wire

3. ❑ Employer pays DOLLAR CONTRIBUTION of $________ per month: ❑ All Employees ❑ All Care Partners
Must identify individuals on the Census supplied with this form. ❑ Select Employees Only ❑ Care Partners of Select Employees
Billing Frequency is ALWAYS Monthly | Pay By (Choose One) ❑ Check ❑ Wire

4. ❑ Voluntary Offer Only — The employer is NOT contributing for any employee

## 3. Payroll Deduction (Only available if 10 or more issued lives)

Is Payroll Deduction an available payment option? ❑ Yes — Must Complete and Sign Payroll Deduction Questionnaire
❑ No

## 4. New Hire Eligibility: When are your New Hires Eligible to Apply? (Check One)

❑ First Day of Hire ❑ After _____ days from Hire Date (Enter #) ❑ Annual Offering to begin the month of ______________ (Enter Month)

## 5. Requested Open Enrollment Dates — Subject to Approval of MedAmerica* (Maximum Initial Enrollment Period is 60 Days)

| | |
|---|---|
| Enter Enrollment Start Date (mm/dd/yyyy) | Enter Enrollment End Date (mm/dd/yyyy) |

* Must submit Census and Completed Forms at least 10 days prior to Open Enrollment Dates.

## 6. Signatures

Your signature below attests to the accuracy of the information provided and confirms your request to offer MedAmerica's Simply Business℠ LTC Program to your employees. You acknowledge an accurate census has been provided. You acknowledge you have read and understand the following: The Employer Offering is subject to pre-approval by MedAmerica. The product and rates may vary by state. Upon approval, MedAmerica will provide written confirmation to you detailing the agreed upon offering.

| | |
|---|---|
| Print Full Name of Authorized Employer Representative | Print Title |
| Signature of Authorized Employer Representative | Date Signed |
| Signature of Agent | Date Signed |

MedAmerica Approval Section

Approved By: ______________________ Date: ______________ MedAmerica Assigned Group #: ______________

THIS PAGE IS INTENTIONALLY LEFT BLANK

# MedAmerica Simply Business℠ Application for Employer Program Census Worksheet

At MedAmerica, we make doing business simple! If you don't have an electronic census for your 3-49 size group, simply fill out this worksheet and our staff will create one for you! See our approval process guide on page 8 for more information on creating a census.

| Name (First & Last Name) | Family Relationship (to owner/officer of company, if any) | Date of Birth | Employment Status (Full Time "F" Part Time "P") | Status Type (Employee, Retiree, Board Member) | State | Marital Status (Married "M" Single "S") | Employer Funded (Full Benefits "1" Defined Benefit "2" $ Contribution "3") |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

You may continue adding census information on the back of this form if necessary.

Authorized Employer Representative: ______________________ Title: ______________________

Signature of Authorized Employer Representative: ______________________ Date: ______________________

MedAmerica Approval Section

Approved By: ______________________ Date: ______________________ Group #: ______________________

# Employer Program Census Worksheet Continued

| Name (First & Last Name) | Family Relationship (to owner/officer of company, if any) | Date of Birth | Employment Status (Full Time "F" Part Time "P") | Status Type (Employee, Retiree, Board Member) | State | Marital Status (Married "M" Single "S") | Employer Funded (Full Benefits "1" Defined Benefit "2" $ Contribution "3") |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

# MedAmerica Simply Business℠ Employee Education & Enrollment Plan

## Required for Employer-Funded Groups and All Groups of 50+ Eligible Employees

### Phase 1: Education & Awareness - 30 days prior to open enrollment (check at least one tool you plan to use and indicate dates )

Dates:

________ ❑ Employee Introduction Letter
On employer's letterhead, signed by employer and mailed to employees, this letter announces the offering of the new plan and lists the dates of the educational meetings.

________ ❑ Management Meeting—Introduction of LTCi Benefit
Introduction of new LTCi benefit and announcement of upcoming events. Confirmation of management support for employee participation and scheduling of management consultations.

________ ❑ Weekly Distribution of Educational Information—Educational e-mails (hard copy available by request)
Series of 5 one-page flyers: Life Can Change on a Dime; We're Not Talking About Pocket Change; Don't Take It Sitting Down; Planning Ahead is One of the Greatest Gifts you Can Give your Family; and Simplicity[ii] Gives You the Flexibility to Keep Your Life on Track.

________ ❑ Announcement of Events—Posters and Tent Cards
Our posters and tent cards can be customized to include your contact information, Web site, open enrollment and seminar details.

________ ❑ Other (Please Describe) ________________________________

### Phase 2: Open Enrollment (check at least one tool you plan to use and indicate dates)

Dates:

________ ❑ Educational Meetings—Key Elements (check all that apply)
- ❑ Conducted at workplace during work hours
- ❑ Employer introduction at each meeting
- ❑ Employer agrees to mandatory attendance & RSVP's
- ❑ Seminar evaluation forms will be collected
- ❑ Personal consultations will be available during work hours
- ❑ Meetings for family members and retirees available
- ❑ Other (Please Describe)________________________________

________________________________

________ ❑ Online Enrollment & Educational Information (where available)
Our turnkey online enrollment system includes educational articles, an easy online enrollment tool and a rate calculator that is available to employees as well as their families and retirees.

________ ❑ Call Center Enrollment
Call Center Phone Number:________________________________

________ ❑ Private Consultations
Use our application booklet and consumer brochure to help eligibles understand their risk so they can make an informed decision about purchasing an LTCi plan.

________ ❑ Employer Reminder Notices to Employees

________ ❑ Ongoing Services— Educational & Enrollment Services are Ongoing
- ❑ New employee enrollment—Simplified underwriting for new actively-at-work employees who apply within 60 days of the date new employee is eligible to participate. (Note: Employer Census required on annual basis.)
- ❑ Ongoing enrollment of employees and family members with full medical underwriting after the open enrollment period ends.

The employer and agent signed below have reviewed and agree to the above timeline and participation in the Employee Education & Enrollment Plan. Each party also understands that materials may vary by state and are subject to approval of the insurer.

Signature of Authorized Employer Representative: ________________________ Date: ________________

Agent Signature: ________________________________ Date: ________________

MedAmerica Approval Section

Approved By: ____________________ Date: ______________ Group #: ________________



COMPLETE AND RETURN

Simplicity[ii]

THIS PAGE IS INTENTIONALLY LEFT BLANK

# MedAmerica Simply Business℠ Application for Employer Program Agent Worksheet

## Employer Information (Required)

Company Name: ____________________

## Agent/Agency Information (Required)

Agent of Record: ____________________ Supervising Agency Name: ____________________

Address: ____________________ City: ____________________ State: _____ Zip: __________

Producer/Agent Writing Number: ____________________ E-mail Address: ____________________

Telephone: ____________________ Fax: ____________________

Follow up questions during & after enrollment should be directed to: (check one) ❑ Agent ❑ Agency

I will be marketing & soliciting in the following states for this case: ____________________

I am licensed & appointed with MedAmerica in all of the above listed states where employees will be solicited: ❑ Yes ❑ No

If no, list states applicable for enrollment of this group where you are not licensed and/or appointed: ____________________

____________________

## Additional Agents Enrolling and/or Splitting Commissions (If applicable)

If additional agents are assisting with the enrollment of this case, please provide the agent's name, writing number and applicable states.

Agent Name: __________ Agent Writing #: __________ States where agent is enrolling: __________

Agent Name: __________ Agent Writing #: __________ States where agent is enrolling: __________

Agent Name: __________ Agent Writing #: __________ States where agent is enrolling: __________

If splitting commissions with additional agents and/or agency, please provide the agent's/agency name, writing number and applicable states.

Agent Name: __________ Agent Writing #: __________ States where agent is enrolling: __________

Agent Name: __________ Agent Writing #: __________ States where agent is enrolling: __________

NOTE: Only appointed agencies/agents may be paid commissions in states where the application is solicited. Appointments will be verified before case approval.

## Agent Projections for Enrollment of Employer Case (Required)

Projected Employee Participation: ______% or _____ # of Employees

Projected Annualized Premium: __________
(During Initial Open Enrollment)

## Enrollment Process (Required)

❑ Web Enrollment

❑ Self Enrollment ❑ Agent Assisted Enrollment (Personal consultation by phone or in person)

❑ Paper Enrollment

## Policy Delivery (Required — check one)

❑ Agent ❑ Agency* ❑ Directly to Insured ❑ Employer*

* Policy delivery should be mailed to the attention of: ____________________

Agent Name: ____________________ Agent Signature: ____________________ Date: __________

MedAmerica Approval Section

Approved By: ____________________ Date: __________ Group #: __________



COMPLETE AND RETURN

Simplicity℠

THIS PAGE IS INTENTIONALLY LEFT BLANK

# MedAmerica Simply Business℠ Payroll Deduction Questionnaire

| Association/Employer Name | Company Assigned Number |
|---|---|

Does your company use a Third Party Administrator for Payroll Deduction?
- ❑ Yes — Go to Section A
- ❑ No — Go to Section B

## Section A — Employer/Association Authorization for MedAmerica to Communicate with Third Party Administrator

By signature below I certify that I am an authorized representative of the Plan Sponsor (Employer/Association Program) and I am authorizing our Third Party Administrator (TPA) to act on our behalf and exchange the necessary information with MedAmerica Insurance Company, MedAmerica Insurance Company of New York, and/or MedAmerica Insurance Company of Florida (MedAmerica) to collect the premiums deducted from our employees salary for payment of the long term care insurance premiums.

| Please Print - Full Name of Authorized Plan Sponsor Representative | Title | Phone Number |
|---|---|---|

| ✍ ✍ Authorized Representative Signature | Date |
|---|---|

## Complete Section C — MedAmerica Will Contact Your TPA

## Section B — Employer/Association Authorization to Communicate Directly with Employer/Association

By signature below I certify that I am an authorized representative of the Plan Sponsor (Employer/Association Program) and I am authorizing MedAmerica to exchange necessary information directly with the Employer/Association named in Section C.

| Please Print - Full Name of Authorized Plan Sponsor Representative | Title | Phone Number |
|---|---|---|

| ✍ ✍ Authorized Representative Signature | Date |
|---|---|

## Complete Section C AND Section D

## Section C — Group Billing Contact Information

| Billing Contact/Third Party Administrator Company Name | Contact First Name, Last Name |
|---|---|

Group Billing Street Address/Mailing Address

| City | State | Zip |
|---|---|---|

| ( ) | ( ) | ❑ AM ❑ PM | |
|---|---|---|---|
| Phone Number | Fax Number | Best Time to Call | E-mail |

## Section D — Payroll Deduction Details

### 1. PAYROLL DEDUCTION IS ALLOWED FOR: (Choose One)

- ❑ Employee Only
- ❑ Employee and Care Partner (Spouse/Domestic Partner)
- ❑ Employee, Care Partner (Spouse/Domestic Partner), and any Family Members that are Eligible for the Program as noted on the application.

### 2. BILLING FREQUENCY (PAYMENT MODE): (Choose One)

- ❑ Monthly (Deductions over the month must equal the Monthly Billed Amount)
- ❑ Bi-Weekly (26 Pay Period Only)

Note: Your billing frequency determines the total amount YOU must deduct from the employee's salary in that time period. For monthly billing, MedAmerica will provide you with the total amount that must be deducted for the month. For bi-weekly billing, MedAmerica will provide you with the total amount that must be deducted every 2 weeks which REQUIRES 26 pay periods for the year. We DO NOT allow 9 or 10 month deduction cycles. All billing frequencies REQUIRE payroll deductions occur over a 12 MONTH DEDUCTION YEAR.

## 3. NUMBER OF PAYROLL CENTERS (Applies to Monthly Billing Only): (Choose one)

a. ❑ One Payroll Center
b. ❑ Two or More Payroll Centers—Send all Payroll Centers on the same monthly bill - No Special Sort needed
c. ❑ Two or More Payroll Centers—Request one monthly bill, sorted by Payroll Center**
d. ❑ Two or More Payroll Centers—Request a separate monthly bill for each Payroll Center**

** To sort monthly bills by Payroll Centers means the Association/Employer agrees to the following:

1. The Association/Employer agrees to provide an Electronic Census with the following information: SSN, Employee Last Name, Employee First Name, Payroll Center.
2. The Association/Employer agrees all Payroll Centers will have Monthly Billing Frequency.
3. If requesting separate bills, the Association/Employer understands and agrees the bill dates will not necessarily be the same.

## 4. PAYROLL DEDUCTION NOTIFICATIONS* — How does MedAmerica notify you of the Payroll Deduction Amount? This is NOT the same as Electronic Billing. This is a pre-notification to the group of the deduction amount needed PRIOR to MedAmerica Billing.

❑ E-mail Notification is used when payroll deductions are manually put into the employer's computer system. ZIXIT security encryption is required for HIPAA compliance: MedAmerica will e-mail a memo of each employee's authorized deduction amount by the 15th of the month with premium due on the 1st of the second month following. (For example: deduction amount provided by August 15th, premium due on October 1.)

❑ Wire Notification is used when payroll deductions are electronically communicated from one computer server to another.
Requirements — If any of the following answers are NO, Wire Notification is NOT available to the Employer.

❑ Yes ❑ No Is the Employer/Association group size 500 Employees or more?
❑ Yes ❑ No Have you attached a payroll schedule?
❑ Yes ❑ No Will you accept the MedAmerica Notification File Format shown on the next page?
❑ Yes ❑ No Do you understand that at least 14 days lead time is needed to set up the electronic transfer?
❑ Yes ❑ No Will you provide MedAmerica a reconciliation file with payment?
❑ Yes ❑ No Do you use Encrypted File Transfer — secure server to secure server?

If yes: Check one of the following: ❑ SFTP ❑ FTP/PGP

Provide an IT Contact Name for setup and testing (required):______________________________

Phone Number:______________________

E-mail Address:______________________

❑ TPA will notify MedAmerica of deduction start date, deduction amount, and effective date as recorded on the TPA authorization. TPA agrees to provide MedAmerica with a copy of the deduction authorization form with the application.

* Note: Payroll Deduction Authorizations: MedAmerica retains an electronic image of the signed authorizations for payroll deduction submitted with each application indefinitely. Copies are available upon request.

## 5. BILLING NOTICE: (Choose one) We do not have Electronic Billing. We do NOT bill until the previous bill is paid.

❑ Paper: MedAmerica will mail a paper bill to the Group Billing Address 3 weeks prior to the due date of the bill — Group will pay as billed.

❑ Group does not require a bill: Group will remit premium deducted with a Reconcilation File detailing the employee name and amount deducted for each employee, and MedAmerica will keep the bill and reconcile from the Group's Reconciliation File (format next page).

## 6. PREMIUM PAYMENT METHOD: (Choose one)

❑ Pay By Check: Employer/TPA will remit paper check with Reconciliation Report** detailing employee name and amount deducted for each employee. If deducting from the employee and their Care Partner: the deductions are listed twice under the employee.

❑ Pay By Wire Transfer: Employer/TPA will wire money to MedAmerica Bank Account and send electronic Reconciliation File** by e-mail.

The Reconciliation Report /File** notifies MedAmerica of changes in employment status, i.e., disability and terminations.

## 7. REFUNDS/ADJUSTMENTS: (Choose one) — How should MedAmerica handle premium adjustments and refunds?

❑ Credit on the Next Group Bill — Group Refunds to Individual.

❑ MedAmerica refunds to the individual directly.

❑ MedAmerica refunds to the Group directly with each bill reconciliation.

## Notification Format Example (Section D, #4)

| Field Name | Length | Value | Offset |
|---|---|---|---|
| Typecode | 1 | "A" Add, "C" Change, "D" Delete | Position 1 |
| Assn | 4 | Group Number | Position 2 - 5 |
| Clientnum | 8 | Subgroup Number | Position 6 - 13 |
| Bill From Date | 8 | MMDDYYYY | Position 14 - 21 |
| Bill To Date | 8 | MMDDYYYY | Position 22 - 29 |
| SS# | *15 | Social Security # for Eligible | Position 30 - 44 |
| Last Name | 30 | | Position 45 - 74 |
| First Name | 15 | | Position 75 - 89 |
| Deduction Amount | 11 | xxxxxxxx.xx | Position 90 - 100 |

* Social Security number will be left justified in the 15 char field

## Payroll Notification Examples (Section D, #4)

| POLICY ISSUE DATE or DATE OF POLICY CHANGE | | NOTIFICATION FILE DATE | PAYROLL DEDUCTIONS OCCUR | BILL FROM | BILL TO | PAYMENT DUE |
|---|---|---|---|---|---|---|
| From Date | To Date | | | | | |
| 6/15/09 | 7/14/09 | 7/15/09 | AUG 2009 | 9/01/09 | 9/30/09 | 9/01/09 |
| 7/15/09 | 8/14/09 | 8/15/09 | SEPT 2009 | 10/01/09 | 10/31/09 | 10/01/09 |
| 8/15/09 | 9/14/09 | 9/15/09 | OCT 2009 | 11/01/09 | 11/30/09 | 11/01/09 |
| 9/15/09 | 10/14/09 | 10/15/09 | NOV 2009 | 12/01/09 | 12/31/09 | 12/01/09 |
| 10/15/09 | 11/14/09 | 11/15/09 | DEC 2009 | 01/01/10 | 01/31/09 | 01/01/10 |

## Payroll Reconciliation Format (Section D, #5)

| Field Name | Length | Value | Offset |
|---|---|---|---|
| SS# | *9 | Soc Security for person responsible | Position 1 - 9 |
| Last Name | 30 | | Position 10 - 39 |
| First Name | 15 | | Position 40 - 54 |
| Deduction Amount | 11 | xxxxxxxx.xx | Position 55 - 65 |
| Check Date/Period End Date | 8 | mm/dd/yy | Position 66 - 73 |