Partially Self-Funded Medical Plan
Set-Up Form

Group Name: _____ **Total Eligible Employees:**_____

ASI Effective Date: _____

HRA ☐ **MERP** ☐

If a change to an existing plan administered by ASI, check below and complete benefit summary on the following pages, sign on the last page and return to ASI.

Change to current plan ☐ Effective date of change in benefits: _____

Is this Plan subject to FMLA?

____ No (1-49 employees) ____ Yes (50+ employees)

Medical Set-Up:
Carrier Name: _____ Medical Plan: _____

Renewal Date of Carrier Plan: _____ Benefit Paid: ☐ Calendar ☐ Other

If moving to ASI from another TPA, would you like a claims run-in? ☐ Yes ☐ No
Run-in Effective Date: _____

If yes, please provide ASI with a Claims History Report from previous TPA.
Name of current TPA: _____

Will pediatric dental be covered under this Plan? ☐ Yes ☐ No
If yes, ASi will process as any other medical service.

EOB Retrieve Program:
Will your company be utilizing this program? ☐ Yes ☐ No

Plan Document:
Is ASI to prepare a plan document? ☐ Yes ☐ No
If you have an existing plan, please include a copy of your current plan document.

Medical Benefit Summary

Deductible: Individual $ _____ Family $ _____ (Is family: ☐aggregate ☐embedded)

Is there an individual payment cap? (Please select **one** of the below options):

- ☐ Only fund plan UNTIL maximum employer exposure has been met. I understand that at times, because of the plan design contains co-pays, there may be an increase or decrease from the stated amount which may result in the employee paying additional amounts.
- ☐ Fund plan through entire carrier deductible. I understand that our maximum exposure may increase or decrease from the amount stated on the proposal and employee schedule of benefits because of the plan design containing co-pays.

Benefit set up information -

Our sales department will work on a schedule of benefits based on your carrier plan and send that over to you and your broker separate. If you have an existing schedule of benefits, please send that to our office so we can review and work with you on keeping the benefits as close to your existing benefit plan. If you have multiple plans, please send over all schedule of benefit information.

Note: If you have any special instructions, please indicate this information below.

Special Instructions (Subject to ASi approval)

_____

_____

_____

_____

_____

_____

Banking Options: Please check option that you want for the administration.

☐ A voided check must be sent to ASI before any claims can be paid. All checks will be prepared on the employer's account, produced by ASI. These checks will be sent to the employer to sign and forward to the provider of services being provided. Please attach a voided check and indicate the starting check number and bank address. **Check starting #** _____
Bank Address _____
_____

☐ ASI opens a separate account for the benefit of the client. ASI prepares the checks then notifies the client of the check run and amount. Client may pre-fund account or fund each check run as provided by ASI. ASI signs, then forwards checks to the provider of service or employee. There is an administration fee from the bank of $25.00 per month. This fee is currently being waived by the bank we utilize. If the bank should require a monthly fee in the future, ASI will pass the cost to the client. **Check in the amount of $ _____ is attached.**

Please select from one of the following options on how your company would prefer to receive the monthly invoices for administrative fees:

☐ U.S. Mail ☐ E-Mail

Please provide the e-mail address if different than what is listed on the application:_____

Client Check List:
ASi Group Application
Set-Up Form
Employee Enrollments

I agree that the attached schedule of benefits drafted for our plan and the fees listed in this set-up form are correct and accurate.

Completed By: _____ **Title:** _____

Signature: _____ **Date:** _____

Once ASI receives all the information on the set up of the group, we will send a welcome kit out to the group contact. This will include forms to utilize during the year, administrative agreement, department contact list and the plan document if ASI prepares it.

ASi Internal Use Only:

Implementation Fees: _____
Per Participant/Per Month: _____
Broker Commission: _____
Annual Fee: _____
Other: _____