

THIRD PARTY ADMINISTRATION SERVICES - EMPLOYER AGREEMENT

GROUP INFORMATION

Group Name: _____ **Effective Date:** _____
Address: _____ **Eligible Employees:** _____
Contact: _____ **Federal Tax ID:** _____
Phone: _____ **Email:** _____

Is Group part of an association? Yes No If yes, association name: _____

SERVICES

homeBASE Administration	Section 125 Plans	COBRA Administration
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental Carrier: _____
<input type="checkbox"/> Grp Life/Disability	<input type="checkbox"/> Flex	<input type="checkbox"/> Flex Carrier: _____
<input type="checkbox"/> Vol Life/Disability	<input type="checkbox"/> HRA	<input type="checkbox"/> Health Carrier: _____
<input type="checkbox"/> Vision	<input type="checkbox"/> HSA	<input type="checkbox"/> HRA Carrier: _____
		<input type="checkbox"/> Vision Carrier: _____

ADMINISTRATION FEES

	Monthly Fee	Set Up Fee	Annual Fee
<input type="checkbox"/> COBRA	\$1.80 per covered employee	---	---
<input type="checkbox"/> homeBASE	All monthly fees waived	---	---
<input type="checkbox"/> Full Flex	\$5.25 per participant***	Waived	\$500*
<input type="checkbox"/> HRA	\$4.50 per employee***	\$450	\$450*
<input type="checkbox"/> Combined Full Flex + HRA	\$8.50 per dual employee***	\$450	\$850*
<input type="checkbox"/> Premium Only Plan (POP)	---	\$250	---*
<input type="checkbox"/> HSA	---	---	\$36 per employee**

* Document change fees may apply **Monthly banking fees may apply ***\$50 monthly minimum

AGREEMENT

The undersigned Group and Insurance Coordinators hereby agree that Insurance Coordinators will provide Third Party Administration (TPA) services for the products and services selected above in accordance with the terms set forth below:

Authorization

Group authorizes Insurance Coordinators and the following to exchange information necessary to administer the products and services purchased:

Insurer(s) (e.g., Delta Dental, VSP, Blue Cross and Blue Shield of Montana)
 Individuals/Entity:

NAME/ENTITY	ADDRESS	PHONE	EMAIL
_____	_____	_____	_____
_____	_____	_____	_____

Responsibilities

1. Group will provide Insurance Coordinators with all required information as needed to execute TPA services for the indicated insurer(s).
2. Insurance Coordinators will provide Group with accurate and timely premium statement/invoices for all products and services selected above.
3. Insurance Coordinators will communicate with Group in regards to any premium billing/invoice issues in a timely manner.

- Group will remit premium and administration fee payments to Insurance Coordinators in a timely manner, and if payment is not received Group will not hold Insurance Coordinators liable for termination or cancellation of coverage.

General

- Group remains the plan administrator while authorizing Insurance Coordinators to provide TPA services for the plan.
- Any payment returned for non sufficient funds (NSF) will incur a minimum \$20 fee.
- The Flexible Benefit Plan Document and/or Employer COBRA Guide include the terms and conditions for the products and/or services purchased.
- If homeBASE Administration is selected, Group will receive one bill for all products and/or services that are supported by homeBASE.
- Group will have access to the Client Services Team for all products and/or Services Purchased.
- This Agreement will be interpreted in accordance with the laws of the State of Montana except to the extent superseded by federal law. Venue and jurisdiction will be in the Montana District Court for Lewis and Clark County. If any provision of this Agreement is held to be invalid, illegal, or unenforceable for any reason, the remainder of this Agreement will remain in effect. Insurance Coordinators is entitled to rely upon, without investigation or inquiry, any written or oral information or communication from Group, its agents or representatives. No changes in or additions to this Agreement will be recognized unless and until made in writing and signed by Group and Insurance Coordinators. This Agreement may be terminated by either party by providing written notice to the other party at least 30 days in advance of the effective date of termination stated in the termination notice. Group and Insurance Coordinators will indemnify and hold each other harmless from and against any and all claims, suits, actions, liabilities, losses, penalties and/or damages including court costs and reasonable attorney’s fees which result from or arise out of the negligent acts or omissions or willful misconduct of either party or its agents or representatives.

IN WITNESS WHEREOF, Group and Insurance Coordinators have caused this Agreement to be executed on their behalf by their duly authorized representatives’ signatures.

_____		Insurance Coordinators	
Group Name			
_____	_____	_____	_____
Authorized Representative Signature	Date	Insurance Coordinators Representative	Date
_____	_____	_____	_____
Title		Title	



WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files an application for insurance containing any materially false information and conceals information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties. The undersigned has read this entire agreement for TPA services and agrees: (a) the information provided is accurate to the best of their knowledge; (b) this application and any other information provided shall serve as the basis for the insurance to be issued; (c) has a duty to notify Insurance Coordinators of any changes.