PROGRAM APPLICATION

EMPLOYER LEGAL NAME:

EMPLOYER ADDRESS:

CITY, STATE & ZIP CODE:

EIN/TAX ID NUMBER: INDUSTRY TYPE:

MAIN CONTACT NAME: TITLE:

PHONE NUMBER: EMAIL:

PROGRAM DESCRIPTION

2023

PLANS & RATES:				
Select Plans	**Plan Design**	**Plan Tier**	**Total**	**Employer Contribution Level**
☐	MEC™ Plan 2	Single	**$222.68**	
		Employee + Spouse	**$294.69**	
		Employee + Child	**$284.03**	
		Family	**$356.04**	
☐	MEC™ Plan 3	Single	**$286.96**	
		Employee + Spouse	**$389.31**	
		Employee + Child	**$368.52**	
		Family	**$470.87**	
☐	IHP Basic™	Single	**$520.30**	
		Employee + Spouse	**$821.57**	
		Employee + Child	**$768.31**	
		Family	**$1,069.59**	
☐	IHP Plus™	Single	**$564.87**	
		Employee + Spouse	**$919.63**	
		Employee + Child	**$848.55**	
		Family	**$1,203.30**	

PLANS & RATES:				
Select Plans	**Plan Design**	**Plan Tier**	**Total**	**Employer Contribution Level**
☐	IHP Premier™	Single	**$599.67**	
		Employee + Spouse	**$978.09**	
		Employee + Child	**$893.61**	
		Family	**$1,272.03**	
☐	IHP Ultimate™	Single	**$713.09**	
		Employee + Spouse	**$1,226.01**	
		Employee + Child	**$1,096.70**	
		Family	**$1,609.65**	

*Total cost consists of administration costs and risk assessment fees; more details available in the Suffolk Service Agreement.

SIGNATURE

By signing this application, signor hereby (i) acknowledges that he/she has been provided the opportunity to review the terms and conditions of the Program(s) selected in this Application, which are available at: https://www.dropbox.com/sh/v90dd7cfqojtb4t/AACMnW0xwNVrYz1QEXoEHLuja?dl=0 and (ii) agrees to be bound by said terms and conditions, as incorporated by reference herein, including but not limited to the Suffolk Service Agreement and the ERISA Plan Documents which form the basis of the plans noted above.

EMPLOYER NAME:

_____

SIGNATURE

BY:

TITLE:

Appointment Form

Reinsurance Coverage: Each Employer is availed attorney-in-fact representation services to facilitate direct procurement of first dollar coverage for claims risks under the plans. Such coverage shall only be provided through a fully licensed and capitalized insurance carrier domiciled in Puerto Rico, which maintains excess reinsurance coverage through one or more A-rated reinsurers to supplement its capital and liquidity.

The following “Appointment Form” authorizes you, the employer, to appoint an authorized attorney (a.k.a. Attorney-in-fact representation) located in Puerto Rico to execute the necessary documents to secure the direct procurement of the first dollar coverage referenced above.

APPOINTMENT FORM

_____, having principal offices at _____ ("Employer") does hereby make, constitute and appoint Charline M. Jiménez-Echevarría, Esq., at address P.O. Box 191134 San Juan, P.R. 00919 true and lawful authorized representative ("Representative"), in Employer's name, place and stead for the sole and limited purpose of completing applications for insurance and directly procuring insurance and renewals thereof, in each case solely on behalf of the health and welfare benefits plan(s) maintained and to be maintained by Employer for the benefit of its eligible plan participants (an "Insurance Policy"), provided that (i) such coverage provides coverage from first dollar to unlimited liability from a carrier licensed and in good standing in the Commonwealth of Puerto Rico (each a "Carrier"), (ii) such coverage gives the Employer the unqualified right to terminate such coverage within 30 days after the issuance of the policy with no penalty and the return of all premiums paid through the date of such termination, and (iii) Representative is otherwise acting in compliance with the laws of the Commonwealth of Puerto Rico (including, without limitation, that Representative holds all proper licenses to carry out his duties hereunder). The Representative is granted full power and authority to do and perform every act and thing whatsoever, that Representative deems requisite or necessary to be done in furtherance of the authority granted hereunder to Representative as fully, to all intents and purposes, as Employer might or could do if present at the doing thereof. Employer, hereby ratifies and confirms all that the said Representative shall do or cause to be done in exercising the powers granted to Representative by virtue hereof. This APPOINTMENT FORM is effective on the Effective Date set forth below. The Representative shall be acting as an authorized representative for Employer, a disclosed principal, and as such the Representative shall not be liable for any premiums or other sums due to the Carrier.

A Carrier may rely upon this APPOINTMENT FORM and any affidavit executed by the Representative attesting to the continued efficacy of this APPOINTMENT FORM without further verification. Such affidavit shall be conclusive evidence that this APPOINTMENT FORM is in full effect on the date of such affidavit, and has not been revoked, terminated or modified.

Upon delivery by Representative to Employer of documentation relating to an Insurance Policy with respect to the coverage described in the first paragraph of this APPOINTMENT FORM that is issued by a Carrier, Representative shall have no right, without prior written consent by Employer, to perform any other actions under this APPOINTMENT FORM or otherwise act as Representative for Employer in any capacity until expiration of such Insurance Policy. Notwithstanding the foregoing, and unless this APPOINTMENT FORM is otherwise terminated by the Employer, Representative shall, under this APPOINTMENT FORM, upon expiration of the Insurance Policy, take all actions necessary to renew the Insurance Policy consistent with the terms, restrictions and limitations set forth in the first paragraph of this APPOINTMENT FORM. Employer may terminate this APPOINTMENT FORM at any time prior to the issuance or renewal of an Insurance Policy by a Carrier by giving Representative written notice. Representative may resign by giving written notice to Employer. Representative may not perform any other activities on behalf of Employer except as expressly authorized herein. Under no circumstances may Representative procure insurance within Employer's home state, i.e., principal place of business, nor will Representative discuss any terms of any insurance policy with Employer prior to or during the process of procuring such insurance policy.

Employer agrees to indemnify, defend, advance defense costs for and hold harmless any Carrier that relies hereon for the purposes of issuing a policy of insurance of the types described in the first paragraph of this APPOINTMENT FORM for and against any claims made by any third party with respect to the actions of the Representative that are within the scope of the grant of authority and powers granted herein to Representative. Employer agrees to indemnify, defend, advance defense costs for and hold harmless the Representative for and against any claims made by any Carrier or any third party with respect to the actions of the Representative that are within the scope of the grant of authority and powers granted herein to Representative.

Employer and Representative agree that Employer shall compensate Representative with a fee of $25.00 per policy procurement and/or renewal for Representative's services hereunder which fee is acknowledged to be fair and reasonable by Employer and Representative.

Oral amendments, oral waivers and purported oral terminations or this APPOINTMENT FORM are void.

Disputes between Employer and Representative shall be determined solely in the Commonwealth of Puerto Rico, Municipality of San Juan. The parties consent to the jurisdiction of such courts and agree that the laws of the Commonwealth of Puerto Rico shall apply to this APPOINTMENT FORM regardless of where the parties are located are formed or reside.

By the signature of Employer below, Employer represents and warrants that it has the authority to enter into this APPOINTMENT FORM with Representative. By the signature of Representative below, Representative accepts the appointment and agrees to act as the Representative for and on behalf of the Employer to the extent of and limited by the terms of this document.

This APPOINTMENT FORM may be executed in multiple counterparts by Employer and Representative.

IN WITNESS WHEREOF, this APPOINTMENT FORM has been executed and shall be effective as of the ___ of _____, 20____ (the "**Effective Date**") on behalf of Employer by a person having the authority to execute and deliver the same and by Representative.

EMPLOYER:	REPRESENTATIVE:
By: _____	By: _____
Print Name of Person Signing: _____	Charline M. Jiménez-Echevarría
Print Title of Person Signing: _____	
Email of Person Signing: _____	Email: rep@cjlegalcounsel.com

APPENDIX B: ADDITIONAL INFORMATION

APÉNDICE B: INFORMACIÓN ADICIONAL

PLAN SPONSOR & PLAN ADMINISTRATOR / **AUSPICIADOR DEL PLAN Y ADMINISTRADOR DEL PLAN**	
PLAN SPONSOR TAX ID NUMBER / **NÚMERO DE IDENTIFICACIÓN PATRONAL DEL AUSPICIADOR DEL PLAN**	
ORIGINAL PLAN EFFECTIVE DATE / **FECHA DE EFECTIVIDAD ORIGINAL**	
WAITING PERIOD/ **PERIODO DE ESPERA**	
NAMED FIDUCIARY / **FIDUCIARIO DESIGNADO**	
AGENT FOR SERVICE OF PROCESS / **AGENTE PARA RECIBIR EMPLAZAMIENTOS**	