Adoption and Employer Contribution Agreement

Sedera & SHA MEC Preventive/MEC Premier

Employer Information:			
Employer Name:			
Street Address:			
City:	State:	Zip:	
Billing Address:			
City:	State:	Zip:	
Tax ID Number:	Phone:		
Authorized Representative (Company Officer):			
Name:	Title:		
Phone:	Email Address:		
Billing Contact:			
Name:	Title:		
Phone:	Email Address:		
Benefits Contact (Healthcare Facilitator):			
Name:	Title:		
Phone:	Email Address:		
Business Type:	Nature of Business:	SIC Code:	Year Established:
Number of Full-Time Employees:	Number of Part-Time Employees:		
Website Address:			
Payroll Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly			
Contribution Payment:			
Contribution payments will be made via ACH. Please include the business name that will be on the checking account, the bank, routing and account number.			
Company Name on Checking Account:			
Bank:			
Routing Number:	Account Number:		
NOTE: Required to document where ACH payments will come from.			

I hereby authorize Bill.com, Inc., on behalf of Shared Health Alliance (SHA), to initiate entries to the bank accounts that I enter, or enable SHA to enter, on the Bill.com, Inc. web site [in order to pay amounts that I owe to SHA in accordance with instructions entered by SHA on the Bill.com web site] and, if necessary, to initiate adjustments for any transactions credited or debited in error. I represent that I have authority to bind the organization that owns the bank accounts, and to authorize all transactions to the bank accounts that are initiated through Bill.com, Inc. I acknowledge that transactions initiated to the bank accounts must comply with the provisions of U.S. law. This authorization will remain in effect until the organization notifies Bill.com, Inc. in writing to cancel it in such time as to afford Bill.com, Inc. and the bank reasonable opportunity to act on it.

☐ I have read, understand and acknowledge the information above and authorize these transactions by signing my full legal name below:

Authorized Signature:	Print Name:

Shared Health Alliance, 3155 Sutton Blvd., Ste. 201, St. Louis, MO 63143 | Phone: 877.232.3811

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Employee:		
Classes: Define if possible		
Class 1:	Class 2:	Class 3:
City:	State:	Zip:
Eligibility:		
Full-Time: Must work at least _____ hours per week		
Coverage Effective:		
1st of the month following: ☐ Date of Hire ☐ 30 days ☐ 60 Days		
Benefits will be offered to: ☐ Full-Time Only ☐ Full-Time and Part-Time		
Benefit Election:		
Effective Date:	Plan Number: N/A	
Employer Code #: N/A	Employer Contract Number: N/A	
Open Enrollment Period:	**From:**	**Through:**
Plans Offered (select only one MEC/IUA combination):		
☐ MEC Preventive + 500 IUA ☐ MEC Premier + 500 IUA ☐ MEC Preventive + 1,000 IUA ☐ MEC Premier + 1,000 IUA ☐ MEC Preventive + 1,500 IUA ☐ MEC Premier + 1,500 IUA ☐ Healthy Essentials Dental/Vision		
Employer Contribution Strategy:		
Fixed Dollar Amount:	Percentage of Premiums:	
Employee Contributions will be paid by:		
Payroll Deduction $		
Signed in: City:	State:	This_____day of_____2020
Signature of Authorized Representative:		
Printed Name of Authorized Representative:		
Title:		

Benefit Broker:		
Agency Name		
Agent:		
Street Address:		
City:	State:	Zip:
Phone:		
Broker to Provide: ☐ W-9 ☐ E&O Insurance ☐ Copy of Insurance License		

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<u>Employer has the right to terminate this agreement at any time during the term.</u> In the event Employer terminates this agreement at any time during the term, Shared Health Alliance will require the following terms:

- **A Sixty-Day (60) Advance Notice of Termination. The 60 days starts on the first of the month following receipt of termination notice or later if requested.**
- **During this Sixty-Day (60) day period, Employer will continue to remit premiums until requested date of termination**
- **As of date of termination, Incurred-But-Not-Reported (IBNR) claims will be paid out of reserves accumulated to-date for Employer. Should claims exceed the reserve, Employer will be billed the cost of those claims plus an administrative expenses for management and adjudication of those claims.**

On or before the effective date of this Agreement, Employer shall deliver by wire or ACH, the initial monthly Remittance Payment pursuant to an updated payroll file; and subsequent remittance payments to:

Shared Health Alliance
Attn: Premium Billing Department
Phone: 877-232-3811

Shared Health Alliance
315 Sutton Blvd
Suite 201
St. Louis, MO 63143

IN WITNESS WHEREOF, the parties hereto have duly executed this Contribution Agreement as of the date and year first above written.

EMPLOYER	Shared Health Alliance
By: _____	By: _____
Name: _____	Name: John Lewis,
Title:_____	Title: COO