STATE OF MISSOURI
DEPARTMENT OF INSURANCE

FORM 1

APPLICATION FOR CERTIFICATE OF AUTHORITY FOR A MULTIPLE EMPLOYER SELF-INSURED HEALTH PLAN (MEWA)

P.O. BOX 690
JEFFERSON CITY, MO 65102-0690

INSTRUCTIONS

This application is to be completed by all Multiple Employer Self-Insured Health Plans who wish to transact business in the State of Missouri.

SECTION A Indicate by check mark the appropriate type of application (and if applicable, the calendar year requested).
SECTION B Complete all identifying data as indicated.
SECTION C The following documents **MUST** be submitted, with this application form, when applying for approval.
SECTION D Instructions for renewing Certificate of Authority.
SECTION E After all previous sections have been completed, the authorized company official must sign in space provided.

SECTION A – TYPE OF APPLICATION

☐ NEW ☐ AMENDED ☐ RENEWAL TO TRANSACT BUSINESS IN THE STATE OF MISSOURI DURING THE YEAR _____

SECTION B – IDENTIFYING DATA

NAME (FULL NAME OF MEWA)				
HOME ADDRESS	STREET	CITY	STATE	ZIP & 4
MAILING ADDRESS	STREET P.O. BOX	CITY	STATE	ZIP & 4

SECTION C – APPLYING FOR APPROVAL

1. Copy of Plan's Bylaws.
2. Schedule of Plan's Benefits.
3. Copies of any Management, Administration and Trust Agreements.
4. copy of aggregate excess stop-loss coverage **AND** individual excess stop loss coverage.
5. Copy of Fidelity Bond(s), in the minimum amount of $150,000 for each Trustee of the Plan.
6. Application fee of $160.00.
7. Most current Audited Financial Report.
8. Service of Process Form (only applicable if Plan is not incorporated in Missouri).
9. Signed agreement between MEWA and each employer of the plan.

SECTION D – INSTRUCTIONS FOR RENEWING CERTIFICATE OF AUTHORITY

The following documents must be submitted, along with this application form, by March 1, for the renewal of the Plan's Certificate of Authority:

1. Renewal fee shall be equal to 2% of the Missouri claims paid by the Plan for the preceding Calendar year.
2. Annual Audited Financial Report

SECTION E - AUTHORIZED OFFICER SIGNATURE

TYPE NAME OF AUTHORIZED OFFICER	SIGNATURE OF AUTHORIZED OFFICER
TITLE	DATE

MO 375-1804 (11-98) EX

STATE OF MISSOURI
DEPARTMENT OF INSURANCE

FORM 2

CONTRACT BETWEEN MULTIPLE EMPLOYER SELF-INSURED HEALTH PLAN AND PARTICIPATING EMPLOYER

The Multiple Employer Self-Insured Health Plan, _____, agrees to provide medical coverage according to the terms and conditions set forth in the written applicable insurance policy to the employees of _____ (employer), provided that:

1. Employer makes regular monthly premium payments in the amount of $ _____ in exchange for the health care benefits provided in the aforementioned insurance policy; and

2. A minimum of seventy-five percent (75%) of the employees on the employer's payroll participate in the health care plan; and

3. There shall be a grace period for late premium payment of thirty days. In the event that the premium is not paid at the end of the thirty days, any claims incurred during that grace period shall not be covered by the health care plan; and

4. Health care coverage pursuant to this plan may not be cancelled provided that premium payments are made and the minimum participation requirement is followed as outlined in numbers one and two above.

5. Employer agrees personally to pay all claims for benefits covered under the plan which are incurred by his/her/its covered employees and their covered dependents, but which the plan or its stop-loss insurer has failed to pay.

I HAVE READ AND UNDERSTAND THE TERMS CONTAINED HEREIN.

SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER

MO 375-1807 (10-93) EX

FORM 3

STATE OF MISSOURI
DEPARTMENT OF INSURANCE

APPLICATION FOR DISSOLUTION OF MULTIPLE EMPLOYER SELF-INSURED HEALTH PLAN

INSTRUCTIONS

This application is to be completed by any Multiple Employer Welfare Arrangement that wishes to terminate a multiple employer self-insured health plan.

SECTION A - IDENTIFYING DATA

NAME (FULL NAME OF NEWA)

ADDRESS (STREET, CITY, STATE, ZIP CODE PLUS 4)

MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP CODE PLUS 4)

SECTION B - DOCUMENTATION

1. List of all Plan's outstanding liabilities, including those incurred but not reported.

2. If applicable, an affidavit from an authorized officer of any licensed insurer attesting to said insurer's irrevocable committment to pay all outstanding liabilities and to provide all related services, including payment of claims, preparation of reports and administration of transactions associated with the period when the plan provided coverage.

3. The names, mailing addresses, telephone numbers, and dates of participation of all employers who have participated in the plan during the last five (5) years.

4. Documentation reflecting the monetary participation during the last five (5) years of each employer listed in number three (3) above.

5. The total contributions to the plan made during the last five (5) years.

SECTION C - AUTHORIZED OFFICER SIGNATURE

TYPE NAME OF AUTHORIZED OFFICER	TITLE

SIGNATURE OF AUTHORIZED OFFICER ▶	DATE

MO 375-1806 (10-93)

EX