

PART I.

A. Plan Sponsor Account Registration

1) *Organization's Name (Must correspond with the information associated with the Federal Employer Tax Identification Number (EIN):

2) *Type of Organization:

Government

Union

Religious

Commercial

Non-profit

3) *Organization's Employer Identification Number (EIN):

4) *Organization's Telephone Number: _____ ext. _____

5) Organization's FAX Number: _____

6) *Organization's Address (must be the address associated with the EIN provided above):

* Street Line 1

* Street Line 2

*City _____ *State/US Territory _____ *Zip Code _____

7) Organization's Website: http:// _____

B. Authorized Representative Invitation

1) *E-mail Address: _____ 2) *Re-enter E-mail Address

3) *First Name _____ 4) Middle Initial (optional): _____ 5) *Last Name

C. Authorized Representative Information

1) *Check box to agree that the Account Manager listed is associated with this plan sponsor

2) *Read and accept the User Agreement and Privacy Policy (located in Part I Section G of this document)

3) *First Name: _____ Middle Initial: _____ *Last Name: _____

4) *Job Title: _____

5) *Date of Birth(Month/Day/Year): _____ 6) *Social Security Number: _____

7) *E-mail Address: _____

8) *Telephone Number: _____ ext _____ 9) FAX Number: _____

Deleted: General Contact Information

Deleted: Information

Deleted: Sponsor's

Deleted: 2) Sponsor's Classification: [dropdown]

Deleted: 4) Phone: _____

Deleted: (optional): _____

Deleted: Company

Deleted: _____

Deleted: _____

City State Zip Code

Deleted: Plan Sponsor

Deleted: Address (optional):

Deleted: 1) Name:

2) Title: _____ [dropdown]

3) Date of Birth: _____

4) Social Security Number: _____ [dropdown]

5) E-mail Address: _____ [dropdown]

6) Phone: _____ [dropdown]

FAX (optional): _____ 7) [dropdown]

8) Address: _____

(If different from Sponsor Address) Street [dropdown]

City State Zip Code [dropdown]

[dropdown]

9) Is this individual authorized to view HIPAA PHI? Yes/No

Deleted: Account Manager

Deleted: 1) Name:

2) Title: _____ [dropdown]

3) Date of Birth: _____

4) Social Security Number: _____ [dropdown]

Deleted: _____

Deleted: 6) Phone: _____ 7) [dropdown]

FAX (optional): _____ [dropdown]

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

An asterisk (*) identifies a required field.

OMB Approval # 0:

10) * Address: _____
 * Street Line 1 _____
 Street Line 2 _____
 *City _____ *State/US Territory _____ *Zip Code _____

11) *Login
 *Login ID: _____
 *Password: _____
 *Re-enter password: _____

*Security Question 1
 *Answer 1 _____

*Security Question 2
 *Answer 2 _____

D. Account Manager Information

1) *Read and accept the User Agreement and Privacy Policy (located in Part I Section G of this document)

2) *First Name: _____ Middle Initial: _____ *Last Name: _____

3) *Job Title: _____

4) *Date of Birth (Month/Day/Year): _____ 5) *Social Security Number: _____

6) *E-mail Address: _____

7) *Telephone Number: _____ 8) FAX Number: _____

9) *Address: _____
 *Street Line 1 _____
 Street Line 2 _____
 *City _____ *State/US Territory _____ *Zip Code _____

10) *Login
 *Login ID: _____
 *Password: _____
 *Re-enter password: _____

*Security Question 1
 *Answer 1 _____

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Deleted: _____ City State Zip Code
 9) Is this individual authorized to view HIPAA PHI? Yes/No

Deleted: Application Designee(s)

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Deleted: 1a) Name:
 1b) Title: _____
 1c) _____

Deleted: : _____
 2d) _____

Deleted: _

Deleted: 1e)

Deleted: 1f) Phone: _____ 1g) _____
 FAX (optional): _____ 1h) _____

Deleted: Street _____

Deleted: _____ City State Zip Code
 1) Is this individual authorized to view HIPAA PHI? Yes/No
 1j) Check the following Parts of the Application that this Designee can edit and/or submit:
 Part I – General Contact Information
 Part II – Plan Information
 Part IV – Electronic Funds Transfer (EFT)
 Part V – Payment Frequency
 Part VI – Retiree List Submission
 1k) Does this Designee have the authority to change and/or submit payment requests? Yes/No
 1l) Does this Designee have the authority to request an extension for application submission? Yes/No
 1m) Does this Designee have the authority to withdraw this application? Yes/No
 1n) Does this Designee have the authority to delete this application? Yes/No
 1o) Does this Designee have the authority to request an appeal? Yes/No

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*Security Question 2
*Answer 2

E. Designee Invitation

1)*E-mail Address: _____ 2)*Re-enter E-mail Address: _____
3)*First Name: _____ 4) Middle Initial (optional): _____ 5)*Last Name: _____
6)*Pass Phrase: _____ 7)*Re-Enter Pass Phrase: _____
8)* Please choose the actions that the designee can perform for this application

F. Designee Information

1) *Enter the Pass-phrase: _____
2)*Read and accept the User Agreement and Privacy Policy (located in Part I Section G of this document)
3) *First Name: _____ Middle Initial: _____ *Last Name: _____ 4) *Job Title: _____
5) *Date of Birth (Month/Day/Year): _____ 6) Social Security Number: _____
7) E-mail Address: _____
8) Telephone Number: _____ ext. _____ 9) FAX Number : _____
10) *Address:

*Street Line 1

Street Line 2

*City _____ *State/US Territory _____ *Zip Code _____
11) *Login
*Login ID: _____
*Password: _____
*Re-enter password: _____
*Security Question 1
*Answer 1
*Security Question 2
*Answer 2

Deleted: 2a) Name: _____
2b) Title: _____
2c) Date of Birth: _____ 2d) Social Security Number: _____
2e) _____

Deleted: -mail Address: _____
2f) Phone: _____
2g) FAX (optional): _____
2h) Address: _____
Street _____
City State Zip Code _____
2i) Is this individual authorized to view HIPAA PHI? Yes/No _____
2j) Check the following Parts of the Application that this

Deleted: can edit and/or submit: _____
 Part I – General Contact Information
 Part II – Plan Information
 Part IV – Electronic Funds Transfer (EFT)
 Part V – Payment Frequency
 Part VI – Retiree List Submission
2k) Does this Designee have the authority to submit and change payment requests? Yes/No _____
2l) Does this Designee have the authority to request an extension for application submission? Yes/No _____
2m) Does this Designee have the authority to withdraw this application? Yes/No _____
2n) Does this Designee have the authority to delete this application? Yes/No _____

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PART II. Plan
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G. User Agreement and Privacy Policy

THE FOLLOWING DESCRIBES THE TERMS AND CONDITIONS ON WHICH THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) OFFERS YOU ACCESS TO CMS' RDS CENTER'S SECURE WEB SITE.

You must read and accept the terms and conditions contained in this User Agreement expressly set out below and incorporated by reference before you may access the RDS Secure Web Site.

CMS' RDS Center may amend this User Agreement at any time. Except as stated below, all amended terms shall automatically be effective 30 days after they are initially posted on the Site. This User Agreement is effective immediately.

1. Purpose of the RDS Secure Web Site

CMS has recently published the final regulations for Title I and Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Title I and its implementing regulations at 42 C.F.R §423 Subpart R contain the provisions governing the Retiree Drug Subsidy (RDS) option designed to assist employers, unions, and other Plan Sponsors that continue to provide high quality prescription drug coverage to their retirees.

The RDS Secure Web Site provides Plan Sponsors with the resources required to become a participant in the RDS Program, including specific instructions and assistance during the application period and afterward.

2. Privacy Policy

The U.S. Department of Health and Human Services (HHS) of which the RDS Secure Web Site is a part, has a clear privacy policy. When you access the RDS Secure Web Site, we collect the minimum amount of information about you necessary to process your application for the RDS Program and to manage your account.

Information Automatically Collected and Stored

When you browse through any web site, certain personal information about you can be collected. We automatically collect and temporarily store the following information about your visit:

- the name of the domain you use to access the Internet (for example, aol.com, if you are using an America Online account, or stanford.edu, if you are connecting from Stanford University's domain)
- the date and time of your visit
- the pages you visited
- the address of the web site you came from when you came to visit

This information is used for statistical purposes only and to help us make this site more useful to visitors. Unless it is specifically stated otherwise, no additional information will be collected about you.

Information Collected to Process Applications and Manage Accounts Through the RDS Secure Web Site

When you apply for the RDS Program through the RDS Secure Web Site, we will collect personal information necessary to validate participants, and to process and manage the application. The authority to collect this information is granted by §1860D-22 of the Social Security Act and CMS' RDS implementing regulations at 42 C.F.R. §423

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Subpart R, as well as the Debt Collection Improvement Act of 1996 at 31 U.S.C. §7701(c) and the Federal Privacy Act at 5 U.S.C. §552a. This may include your name, address, telephone and fax numbers, e-mail address, social security number, drivers license photocopy, Federal Employer Identification Number (FEIN), banking information or other payment information. Provision of this information is mandatory for participation in the RDS Program. CMS' RDS Center may also collect a password and password hint for each participant accessing the RDS Secure Web Site. We use this information to verify participants' identities in order to prevent unauthorized access to secure RDS Secure Web Site accounts.

CMS' RDS Center staff has role-based access to this information, and use only the information minimally necessary to accomplish their jobs.

The personal information you provide is encrypted and sent to us using a secure method, in order to assure that your personal information is securely and safely transmitted. However, no one can give an absolute assurance that information intended to be maintained as private, whether transmitted via the Internet or otherwise, cannot be accessed inappropriately or unlawfully by third parties. We have taken and will continue to take reasonable steps to ensure the secure and safe transmission of your personal information.

Personally Provided Information

If you are not involved with the submission or management of an RDS Program application on the RDS Secure Web Site, you do not have to give us personal information. If you choose to provide us with additional information about yourself through e-mail, forms, surveys, etc., we will maintain the information as long as needed to respond to your question or to fulfill the stated purpose of the communication.

Disclosure

HHS and CMS do not disclose, give, sell or transfer any personal information about its visitors, unless required for law enforcement or statute.

Intrusion Detection

The RDS Web Sites are maintained by the U.S. Government. It is protected by various provisions of Title 18, U.S. Code. Violations of Title 18 are subject to criminal prosecution in Federal court.

For site security purposes and to ensure that this service remains available to all participants, we employ software programs to monitor traffic to identify unauthorized attempts to upload or change information, or otherwise cause damage. In the event of authorized law enforcement investigations, and pursuant to any required legal process, information from these sources may be used to help identify an individual.

3. Systems of Records

Information originally collected in traditional paper systems can be submitted electronically, i.e., electronic commerce transactions and information updates about eligibility benefits. Electronically submitted information is maintained and destroyed pursuant to the Federal Records Act and in some cases may be subject to the Privacy Act. If information that you submit is to be used in a Privacy Act system of records, there will be a Privacy Act Notice provided.

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4. Links

References from RDS web sites to any non-governmental entity, product, service or information do not imply endorsement or recommendation by CMS, HHS or any other HHS agency or employees.

We are not responsible for the contents of any "off-site" web pages referenced from this server. We do not endorse ANY specific products or services provided by public or private organizations. In addition, we do not necessarily endorse the views expressed by such sites, nor do we warrant the validity of any site's information or its fitness for any particular purpose.

5. Pop-up Advertisements

When visiting RDS web sites, your web browser may produce pop-up advertisements. These advertisements were most likely produced by other web sites you visited or by third party software installed on your computer. CMS does not endorse or recommend products or services for which you may view a pop-up advertisement on your computer screen while visiting our site.

6. Outdated Information

Many HHS/CMS documents are time sensitive. Department policies change over time. Information in older documents may be outdated. You also may wish to review our Privacy Policy in section 2.

7. Accessibility

This page provides information for those visitors who use assistive or other devices to access the content on the RDS web sites. Please see Contact Us at if you have general questions and comments or have difficulty finding something on this site.

Synopsis of Section 508 Accessibility Requirements

The Centers for Medicare & Medicaid Services (CMS) Retiree Drug Subsidy (RDS) Program is committed to making all RDS Web Sites accessible to the widest possible audience, including individuals with disabilities. In keeping with its mission, the RDS Center complies with the regulations of Section 508 of the Rehabilitation Act and the Department of Health & Human Services (HHS) Section 508 Implementation Policy. The information contained within the RDS Web Sites are intended to be accessible through screen readers and other accessibility tools. If alternative means of access to any information contained on RDS Web Sites are needed, or interpreting any information proves difficult, please contact the RDS Help Line. Call (877) RDS-HELP or (877) 737-4357. TTY for hearing impaired: (877) RDS-TTY0, or (877) 737-8890. E-mail rds@cms.hhs.gov. In an e-mail, please indicate the nature of the accessibility problem including the accessibility tool and web browser used, the web page address that is causing difficulty, contact name, e-mail address, and phone number. Please do not include any Protected Health Information (PHI), as defined in the Health Insurance Portability and Accountability Act (HIPAA), in the e-mail.

8. Freedom of Information Act (FOIA)

The RDS Web Sites are a service of the U.S. Department of Health and Human Services. Any Freedom of Information Act (FOIA) requests concerning the RDS Web Sites should be submitted in accordance with the Department's FOIA guidelines. Information on making FOIA requests is available at the Freedom of Information Group page. You also may

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An asterisk (*) identifies a required field.

OMB Approval # 0:

wish to review our Privacy Policy in Section 2.

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CMS Form # 10156

An asterisk (*) identifies a required field.

OMB Approval # 0:

PART II.

A. Plan Information

1) *Plan Name: _____ 2) *Plan Year - Start Date: _____ End Date: _____

B. Benefit Option(s) Provided Under This Plan

1a) *Benefit Option Name: _____
 1b) *Unique Benefit Option Identifier: _____
 1c) *Benefit Option Type: Self-Funded _____ Insured _____ Both _____
 1d) Benefit Administrator Company Name: _____

C. Actuary Invitation

1)*First Name: _____ 2)Middle Initial: _____ 3)*Last Name: _____
 4)* Actuary AAA Membership Number: _____
 5)*E-mail Address: _____ 6)*Re-enter E-mail Address: _____

D. Actuary Information

1)* Actuary AAA Membership Number: _____
 2)*Read and accept the User Agreement and Privacy Policy (located in Part I Section G of this document)
 3)*First Name: _____ Middle Initial (optional): _____ *Last Name: _____
 4) *Social Security Number: _____ 5) *Date of Birth (Month/Day/Year): _____
 6)Job Title: _____ 7)Actuary's Company Name: _____
 8) *E-mail Address: _____
 9) *Phone Number: _____ 10) FAX Number : _____
 11) *Address: _____

 Street 1

 Street 2

 *City _____ *State/US Territory _____ *Zip Code _____
 12) *Login
 *Login ID: _____
 *Password: _____

Deleted: ¶
3) Are you combining two or more benefit options (listed in Part II(B)) for the purpose of demonstrating that the plan meets the actuarial equivalence Net Test? Yes/No

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Deleted: 1e) Name of Attesting Actuary: _____ 1f) AAA

Membership Number: _____ ¶

1g) Job Title: _____ ¶

1h)Actuary Company Name (optional): _____ 1i) E-mail

Address: _____ ¶

1j) Phone: _____

1k) FAX (optional): _____ ¶

1l) Address: _____

_____ ¶

Street¶

_____ ¶

City _____ State

Zip Code¶

Deleted: 2a) Benefit Option Name: _____ ¶

2b) Unique Benefit Option Identifier: _____ ¶

2c) Benefit Option Type: Self-Funded ... [1]

Deleted: : _____

2f) AAA Membership Number: _____ ¶

_____ [2]

Deleted: Click here to add more benefit options

Deleted: C. Contact

Deleted: for the Actuary Attesting to the Net Value of the Combined Benefit Options

Deleted:) Name: _____

2) _____

Deleted: _____

Deleted: 3) Company Name: _____

_____ ¶

_____ [3]

Deleted: _____

Deleted: _____

Deleted: 3) Company Name: _____

_____ ¶

_____ [3]

Deleted: _____

Deleted: _____

Deleted: _____

_____ City _____ State _____ Zip Code

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An asterisk (*) identifies a required field.

OMB Approval # 0:

*Re-enter password: _____

*Security Question 1

*Answer 1

*Security Question 2

*Answer 2

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CMS Form # 10156

PART III.

A. Benefit Option Combination Question

1)*In calculating the actuarial Net Value of the benefit option(s) listed in this Plan Sponsor Application (Please select one of the following:

(i) Each Benefit Option individually meets the Net Value test as set forth at 42 C.F.R. §423.884(d)

(ii) Two or more Benefit Options have been combined in order to meet the Net Value test as set forth at 42 C.F.R. 423.884(d), and each option not so combined individually meets the Net Value test as set forth in 42 C.F.R. §884

Note: Based on the answer to the above question the actuary will be presented with the corresponding Actuarial Attestation agreement. (B (i) or B (ii)).

B (i). *Actuarial Attestation for the Gross and Net Value Tests if no Benefit options are combined

I hereby attest to the following:

I am a qualified actuary and a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) Actuarial Attestation.

The actuarial Gross Value of each of the Benefit Option(s) listed in this Plan Sponsor Application is at least equal to the actuarial Gross Value of the defined standard prescription drug coverage under Medicare Part D for the Medicare Part D eligible individuals who are participants and beneficiaries of the Plan Sponsor's plan for the subject plan year.

I have determined that each of the Benefit Option(s) listed in this Plan Sponsor Application meet the Gross Value Test requirements of 42 C.F.R. §423.884(d), including the relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.

Each Benefit Option individually meets the Net Value test as set forth at 42 C.F.R. §423.884(d).

The actuarial Net Value of the Benefit Option(s) listed in this Plan Sponsor Application is at least equal to the actuarial Net Value of the defined standard prescription drug coverage under Medicare Part D for the Medicare Part D eligible individuals who are participants and beneficiaries of the Plan Sponsor's Plan for the subject plan year.

The Net Value of the Plan Sponsor's prescription drug coverage was determined using a methodology consistent with the requirements set forth at 42 C.F.R. §423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.

I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.

I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.

I certify that this attestation is true and accurate to the best of my knowledge and belief.

Electronic Signature

Deleted: Attestation of Actuarial Equivalence

Deleted: Actuarial Attestation Used When Benefit Options are Combined

Deleted: (A)(i). Actuarial Attestation for the Gross Value Test

Deleted: I hereby attest to

Deleted: following:¶ I am a qualified actuary

Deleted: a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) Actuarial Attestation. ¶ The actuarial Gross

Deleted: of the benefit option(s) is at least equal to the actuarial Gross Value of the defined standard prescription drug coverage under Part D for the Part D eligible individuals who

Deleted: participants and beneficiaries of the sponsor's plan for the subject plan year.¶ The Gross Value of the option listed in section II(B) of this application was determined using a methodology consistent with the requirements set forth at 42 C.F.R. 423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.¶ I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.¶ I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.¶ I certify that this attestation is true and accurate to the best of my knowledge and belief.¶ ¶ Electronic Signature

Deleted: (A)(ii). Actuarial Attestation for the Net Value Test

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

B(ii). * Actuarial Attestation for the Gross and Net Value Tests if benefit options are combined

I hereby attest to the following:

I am a qualified actuary and a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) actuarial attestation.

The actuarial Gross Value of each of the Benefit Option(s) listed in this Plan Sponsor Application is at least equal to the actuarial Gross Value of the defined standard prescription drug coverage under Medicare Part D for the Medicare Part D eligible individuals who are participants and beneficiaries of the Plan Sponsor's plan for the subject plan year.

I have determined that each of the Benefit Option(s) listed in this Plan Sponsor Application meet the Gross Value Test requirements of 42 C.F.R. §423.884(d), including the relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.

Two or more Benefit Options have been combined in order to meet the Net Value test as set forth at 42 C.F.R. 423.884(d), and each option not so combined individually meets the Net Value test as set forth in 42 C.F.R. §884(d)

The actuarial Net Value of the Benefit Option(s) listed in this Plan Sponsor Application is at least equal to the actuarial Net Value of the defined standard prescription drug coverage under Medicare Part D for the Medicare Part D eligible individuals who are participants and beneficiaries of the Plan Sponsor's Plan for the subject plan year.

The Net Value of the Plan Sponsor's prescription drug coverage was determined using a methodology consistent with the requirements set forth at 42 C.F.R. §423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.

I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.

I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.

I certify that this attestation is true and accurate to the best of my knowledge and belief.

Electronic Signature

Deleted: I hereby attest to

Deleted: following:¶
I am a qualified actuary

Deleted: a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) actuarial attestation. ¶
The actuarial

Deleted: of the Plan Sponsor's prescription drug plan (consisting of the combined

Deleted: listed in section II(B)) is at least equal to the actuarial Net Value of the defined standard prescription drug coverage under Part D for the Part D eligible individuals who

Deleted: participants and beneficiaries of the Sponsor's Plan for the subject plan year.¶
The Net Value of the Plan Sponsor's prescription drug coverage was determined using the methodology consistent with the requirements set forth at 42 C.F.R. 423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.¶
I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.¶
I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.¶
I certify that this attestation is true and accurate to the best of my knowledge and belief.¶
¶
Electronic Signature

Deleted: B. Actuarial Attestation for the Gross Value and Net Value Tests When the Benefit Options are Not Combined

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PART IV.

1) *Bank Name: _____

2) *Bank Address: _____

 *Street 1

 Street 2

 *City *State/US Territory *Zip Code

3) *Account Number: _____

4) *Name of Organization Associated with Account: _____

5) *Account type: Checking Account Savings Account

6) *Bank Routing Number: _____

7) *Bank Contact *First Name Middle Initial: *Last Name: _____

8) E-mail address: _____

9) *Telephone Number: _____

Deleted: I hereby attest to the following.¶
 I am a qualified actuary and a member of the American Academy of Actuaries. I am familiar with the requirements for, and am qualified to prepare, a Retiree Drug Subsidy (RDS) Actuarial Attestation. ¶
 The actuarial Gross Value and Net Value of the benefit option is at least equal to the actuarial Gross Value and Net Value of the defined standard prescription drug coverage under

Deleted: D for the Part D eligible individuals who are participants and beneficiaries of the sponsor's plan for the subject plan year.¶
 The Gross Value and Net Value of the option listed in section II(B) of this application was determined using a methodology consistent with the requirements set forth at 42 C.F.R. 423.884(d)(5) and all relevant actuarial guidelines issued by CMS, and the data and assumptions used in the development of this attestation are reasonable and are based on generally accepted actuarial principles, including the appropriate actuarial standards of practice.¶
 I understand and acknowledge that the information being provided in this attestation is being used to obtain Federal funds.¶
 I agree to maintain and make available reports, working documents and other records as required under 42 C.F.R. 423.888(d). This includes information about data and/or assumptions I may have relied upon.¶
 I certify that this attestation is true and accurate to the best of my knowledge and belief.¶
 ¶
 Electronic Signature ☐¶

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PART IV. Electronic Fund Transfer (EFT) Information

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

An asterisk (*) identifies a required field.

OMB Approval # 0:

PART V.

Please select one of the following payment frequencies:

- 1) Monthly
- 2) Quarterly
- 3) Interim Annual
- 4) Annual

Deleted: 1) Bank Name:

2) Bank Address: _____
 Street

 City State
 Zip Code
 3) Account Number: _____ 4)
 Name on Account: _____
 5) Checking Account Savings
 Account
 6) Bank Routing Transit Number:

 7) Bank Contact Person: _____
 8) E-mail address: _____

 9) Phone: _____

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 payment frequencies:
 <#> Monthly
 <#> Quarterly
 <#> Interim Annual
 <#> Annual

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PART VI.

Deleted: Retiree List Submission

A. Retiree Data Electronic Data Interchange (EDI) Method

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Note: The Plan Sponsor must provide the EDI details for each benefit option. These fields may be applied to multiple benefit options or may be filled in for each benefit option individually.

Deleted: <#> Hypertext Transfer Protocol Secure (HTTPS) to RDS Center
<#> Plan Sponsor Mainframe to RDS Center Mainframe (Please note that if you elect this option a representative from the RDS Center will contact the Plan Sponsor Technical Contact.)
2a) Plan Sponsor Technical Contact Name: _____
2b) Plan Sponsor Technical Contact Phone Number: _____
2c) Plan Sponsor Technical Contact E

1) * Retiree List Submission Method

- Hypertext Transfer Protocol Secure (HTTPS) to RDS Center
- Plan Sponsor or Vendor Mainframe to RDS Center Mainframe
- Voluntary Data Sharing Agreement (VDSA) via the Coordination of Benefits (COB) Contractor

2)*Mainframe Vendor ID or VDSA Contractor ID (not required for HTTPS): _____

3)*Name of Organization Submitting Retiree List _____

4)*Technical Contact: First Name: _____ Middle Initial: _____ *Last Name: _____

5)*E-mail Address: _____

6)*Re-Enter E-mail Address: _____

7)*Telephone Number: _____ ext _____ 8)FAX Number : _____

9)* Address:

* Street Line 1

Street Line 2

*City _____ *State/US Territory _____ *Zip Code _____

10)*Method of retiree notification file transmission (will be limited to the retiree list submission method and HTTPS)

- Hypertext Transfer Protocol Secure (HTTPS) from RDS Center
- RDS Center Mainframe to Plan Sponsor or Vendor Mainframe
- Voluntary Data Sharing Agreement (VDSA) via the Coordination of Benefits (COB) Contractor

B. Retiree List

Plan Sponsors must submit an electronic list of retirees for whom they are seeking subsidy payments. For each retiree the following data elements must be provided:

- Application ID (assigned to you by the RDS Center)
- Unique Benefit Option Identifier – This should be the same as the Unique Benefit Option Identifier entered in Part II (B).
- Effective Date – This should either be the first day of the Plan Year, or the first date of coverage for the Retiree under the Plan, whichever is later.
- Termination Date – The last date of coverage for the Retiree under the Plan, if known. If unknown, leave it

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

An asterisk (*) identifies a required field.

OMB Approval # 0:

- blank.
- First name
- Last name
- Middle initial (optional)
- Social Security Number (SSN) and/or Medicare Health Insurance Claim Number (HICN)
- Date of Birth
- Gender
- Relationship to the Retiree (self, spouse, dependent)
- Type of record (add, update, delete)

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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PART VII	
1.	Compliance. In order to receive subsidy payment(s), <u>Plan Sponsor</u> agrees to comply with all of the terms and conditions of 42 C.F.R. §423 Subpart R and in other guidance issued by CMS, including, <u>but not limited to</u> , the conditions for submission of <u>data</u> for obtaining payment and the record retention requirements.
2.	Notice of Creditable Coverage: <u>Plan Sponsor</u> certifies that it has provided or will provide prior to the beginning of the plan year <u>referenced in this Plan Sponsor application</u> , creditable coverage notices in accordance with 42 C.F.R. §423.56 to Part D eligible individuals covered under the <u>Plan Sponsor's</u> plan.
3.	Written Agreement: <u>Plan Sponsor</u> certifies that, <u>prior to the first day of the plan year specified in this Plan Sponsor application</u> , it has executed a written agreement with its health insurance issuer or group health plan regarding disclosure of information to CMS, and the issuer or plan agrees to disclose to CMS, on behalf of the <u>Plan Sponsor</u> , the information necessary for the <u>Plan Sponsor</u> to comply with the requirements of the RDS Program.
4.	Use of Records: <u>Plan Sponsor</u> understands and agrees that officers, employees and contractors of the Department of Health and Human Services, including the Office of Inspector General (OIG), may use information collected under the RDS Program only for the purposes of, and to the extent necessary in, carrying out their responsibilities under 42 C.F.R. §423 Subpart R including, but not limited to, determination of payments and payment-related oversight and program integrity activities, or as otherwise required by law. This restriction does not limit OIG authority to conduct audits and evaluations <u>necessary for purposes of 42 C.F.R. §423 Subpart R</u> or other authority.
5.	Obtaining Federal Funds: <u>Plan Sponsor</u> acknowledges that the information furnished in its <u>Plan Sponsor application</u> is being provided to obtain Federal funds. <u>Plan Sponsor</u> certifies that it requires all subcontractors, including plan administrators, to acknowledge that information provided in connection with the subcontract is used for purposes of obtaining Federal funds. <u>Plan Sponsor</u> acknowledges that payment of a subsidy is conditioned on the submission of accurate information. <u>Plan Sponsor</u> agrees that it will not knowingly present or cause to be presented a false or fraudulent claim. <u>Plan Sponsor</u> acknowledges that any overpayment made to the <u>Plan Sponsor</u> under the RDS program, <u>or any debt that arises from such overpayment</u> , may be <u>recovered</u> by CMS. <u>Plan Sponsor</u> will promptly <u>update</u> any changes to the information submitted in its <u>Plan Sponsor application</u> . <u>If Plan Sponsor becomes aware that information in this application is not (or is no longer) true, accurate and complete, Plan Sponsor agrees to notify CMS promptly of this fact.</u>
6.	Data Security: <u>Plan Sponsor</u> agrees to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this <u>Plan Sponsor application</u> . <u>Plan Sponsor</u> recognizes that the use and disclosure of protected health information (PHI) is governed by the Health Insurance Portability and Accountability Act (HIPAA) and accompanying regulations. <u>Plan Sponsor</u> certifies that its retiree group health plan(s) has established and implemented appropriate safeguards in compliance with 45 C.F.R. Parts 160, 162 and 164 (HIPAA administrative simplification, privacy and security rule) in order to prevent unauthorized disclosure of such information or data. <u>Sponsor</u> also agrees that if it participates in the administration of the plan(s), then it has also established and implemented the same safeguards in compliance with the above HIPAA citations. Any and all <u>Plan Sponsor</u> personnel interacting with <u>PHI</u> shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.
7.	Depository Information: <u>Plan Sponsor</u> hereby authorizes CMS to initiate payment, credit entries and other adjustments, including offsets and requests for payment, in accordance with the provisions of 42 C.F.R. §423 Subpart R <u>and applicable provisions of 45 CFR Part 30</u> , to the account at the financial institution (hereinafter the "Depository") indicated <u>under the Electronic Funds Transfer (EFT) section</u> of the <u>Plan Sponsor application</u> . <u>Plan Sponsor</u> agrees to <u>immediately pay back any overpayment or debt upon notification from CMS of the overpayment or debt</u> . <u>Plan Sponsor</u> agrees to <u>promptly update</u> any changes in its Depository information.

Deleted: . Plan Sponsor Agreement

Deleted: for obtaining the retiree drug subsidy and as outlined in

Deleted: .880 et. seq., (

Deleted:)

Deleted: cost

Deleted: (For year one of the RDS program Sponsor certifies that it will execute the written agreement prior to January 1, 2006.)

Deleted: under

Deleted: retiree drug subsidy

Deleted:

Deleted:

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Deleted: recouped

Deleted: /RDS Contractor.

Deleted: notify CMS of

Deleted: Agreement.

Deleted: RDS Application.

Deleted: this data

Deleted:

Deleted: in Part IV(A)(1)

Deleted: Application. When

Deleted: know of, and

Deleted: , an

Deleted: it must pay that amount back to CMS. Sponsor agrees to promptly notify

Deleted: and submit an update EFT Authorization

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

8. **Change of Ownership:** The **Plan Sponsor** shall provide written notice to CMS, at least 60 days prior to a change in ownership, as defined in 42 CFR §423.892(a). When a change of ownership results in a transfer of the liability for prescription drug costs, this Plan Sponsor Agreement is automatically assigned to the new owner, who shall be subject to the terms and conditions of this Plan Sponsor Agreement.

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PART VIII.

Deleted: Plan Sponsor Electronic Signature

Signature of Plan Sponsor Authorized Representative

I, the undersigned Authorized Representative of **Plan Sponsor**, declare that I have examined this **Plan Sponsor** Application and Plan Sponsor Agreement. My signature legally and financially binds the **Plan Sponsor** to the laws, regulations, and other guidance applicable to the RDS program (including, but not limited to 42 C.F.R. §423 Subpart R) and all other applicable laws and regulations. I certify that the information contained in this **Plan Sponsor** Application and Plan Sponsor Agreement is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. I understand that, because payment of a subsidy will be made from Federal funds, any false statements, documents, or concealment of a material fact is subject to prosecution under applicable Federal and/or State law.

Electronic Signature

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Deleted: If I become aware that information in this application is not (or is no longer) true, accurate and complete, I agree to notify CMS/RDS Contractor promptly of this fact.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0957. The time required to complete this information collection is estimated to average 64 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Page 8: [1] Deleted Author

- 2a) Benefit Option Name: _____
- 2b) Unique Benefit Option Identifier: _____
- 2c) Benefit Option Type: Self-Funded _____ Fully Insured _____ Both _____
- 2d) Benefit Administrator Company Name: _____
- 2e) Name of Attesting _____

Page 8: [2] Deleted Author

- : _____ 2f) AAA Membership Number: _____
- 2g) Job Title: _____
- 2h) Actuary Company Name (optional): _____ 2i) E-mail Address: _____
- 2j) Phone: _____ 2k) FAX (optional): _____
- 2l) Address: _____
Street _____
City _____ State _____ Zip Code _____

Page 8: [3] Deleted Author

- 3) Company Name: _____
- 4) E-mail Address: _____
- 5) Phone: _____ 6) FAX (optional): _____
- 7) _____

Page 13: [4] Deleted Author

Please select one of the following payment frequencies:

- Monthly
- Quarterly
- Interim Annual
- Annual