ERRP

Early Retiree Reinsurance Program Application

~~*Information Collection*~~

U.S. Department of Health and Human Services

HHS Form # ~~INSERT NUMBER~~CMS-10321

~~Application Information~~

Please note that if any information in this Application changes or if the sponsor discovers that any information is incorrect, the sponsor is required to promptly report the change or inaccuracy.

An asterisk (*) identifies a required field. -

PART I: Plan Sponsor and Key Personnel Information

A. Plan Sponsor ~~Account Registration~~ Information

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

2) *Type of Organization (Check the one category that best describes your 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 Address:_____

~~**B. Authorized Representative Invitation**~~

~~1)*Email Address: _____~~

~~2)*First Name _____ Middle Initial (optional): ____ *Last Name _____~~

~~C~~**B. 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 (optional): ____ *Last Name: _____

~~4~~2) *Job Title: _____

~~5~~3) *Date of Birth(Month/Day/Year):_____

~~6~~4) *Social Security Number: _____

~~7~~5) *Email Address: _____

~~8~~6) *Telephone Number: _____ext_____

~~9~~7) FAX Number:_____

~~10~~8) *Employer Name: _____

~~11~~9) * Authorized Representative Business Address:

* Street Line 1: _____

Street Line 2: _____

*City: _____

*State/US Territory: _____

*Zip Code: _____

~~12) *Login Information~~

~~*Login ID: _____~~

~~*Password: _____~~

~~*Security Question 1: _____~~

~~*Answer 1: _____~~

~~*Security Question 2: _____~~

~~*Answer 2: _____~~

~~D~~C. 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 (optional): ____ *Last Name: _____

~~3~~2) *Job Title: _____

~~4~~3) *Date of Birth(Month/Day/Year):_____

~~5~~4) *Social Security Number: _____

~~6~~5) *Email Address: _____

~~7~~6) *Telephone Number: _____ext_____

~~8~~7) FAX Number:_____

~~9~~8) *Employer Name: _____

~~10~~9) *Account Manager Business Address:

* Street Line 1: _____

Street Line 2: _____

*City: _____

*State/US Territory: _____

*Zip Code: _____

~~11) Login Information~~

~~*Login ID: _____~~

*Password: _____
*Security Question 1: _____
*Answer 1: _____
*Security Question 2: _____
*Answer 2: _____

E. Designee Invitation

1)*Email Address:_____

2)*First Name: _____ Middle Initial (optional): ____ *Last Name: _____

3)*Pass Phrase: _____

4)* Please indicate 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 (optional):___ *Last Name:_____

4) *Job Title: _____

5) *Employer Name: _____

6) *Date of Birth (Month/Day/Year): _____

7) *Social Security Number: _____

8) *Email Address: _____

9) *Telephone Number: _____ext._____

10) FAX Number :_____

11)*Address:

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

12) Login Information
*Login ID: _____
*Password: _____
*Security Question 1: _____
*Answer 1: _____
*Security Question 2: _____
*Answer 2: _____

G. User Agreement and Privacy Policy

THE FOLLOWING DESCRIBES THE TERMS AND CONDITIONS ON WHICH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) OFFERS YOU ACCESS TO HHS'' EARLY RETIREE REINSURANCE PROGRAM (ERRP) 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 ERRP Secure Web Site. HHS 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 ERRP Secure Web Site

The ERRP Secure Web Site provides Plan Sponsors with the resources required to become a participant in the Early Retiree Reinsurance Program described in Section 1102 of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), and regulations at 45 CFR Part149.

2. Privacy Policy

HHS, of which the ERRP Secure Web Site is a part, has a clear privacy policy. When you access the ERRP Secure Web Site, we collect the minimum amount of information about you necessary to process your application for the Early Retiree Reinsurance Program and to manage your account.

3. 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, serviceprovider.com, where "serviceprovider" would be the name of the entity providing your access to the Internet)
- 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.

4. Information Collected to Process Applications and Manage Accounts Through the ERRP Secure Web Site

When you apply for the ERRP through the ERRP Secure Web Site, HHS will collect personal information necessary to validate participants, and to process and manage the application. The authority to collect this information is granted by §1102 of PPACA (P.L. 111-148) and HHS ERRP implementing regulations at 45 CFR Part 149 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, Email address, social security number, drivers license photocopy, Federal Employer Identification Number (EIN), banking information, or other reimbursement information. Provision of this information is mandatory for participation in the ERRP. HHS may also collect a password and password hint for each participant accessing the ERRP Secure Web Site. We use this information to verify participants' identities in order to prevent unauthorized access to secure ERRP Secure Web Site accounts.

HHS 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 HHS 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. HHS has taken and will continue to take reasonable steps to ensure the secure and safe transmission of your personal information.

5. Personally Provided Information

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

6. Disclosure

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

7. Intrusion Detection

The ERRP Web Sites are maintained by the U.S. Government and are 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.

8. 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.

9. Links

References from ERRP web sites to any non-governmental entity, product, service or information do not imply endorsement or recommendation by 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.

10. Pop-up Advertisements

When visiting ERRP 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. HHS 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.

11. Outdated Information

Many HHS 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.

12. Accessibility

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

13. Synopsis of Section 508 Accessibility Requirements

HHS is committed to making all ERRP Web Sites accessible to the widest possible audience, including individuals with disabilities. In keeping with its mission, HHS complies with the regulations of Section 508 of the Rehabilitation Act and the HHS Section 508 Implementation Policy. The information contained within the ERRP Web Sites is intended to be accessible through screen readers and other accessibility tools. If alternative means of access to any information contained on ERRP Web Sites are needed, or interpreting any information proves difficult, please contact the ERRP Contact Center via telephone or Email. In an Email, 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, Email 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 Email.

14. Freedom of Information Act (FOIA)

The ERRP Web Sites are a service of HHS. Any Freedom of Information Act (FOIA) requests concerning the ERRP 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 at http://www.hhs.gov/foia/. You also may wish to review our Privacy Policy in Section 2.

PART II: Plan Information

A. Plan Information

1) *Plan Name:

2) *Plan Year Cycle: Start Month/Day:_____ End Month/Day: _____

B. Benefit Option(s) Provided Under This Plan **(If the plan has more than one benefit option for which you intend to seek program reimbursement, please include the information below for each benefit option, on a separate copy of the Attachment below.**

1a) *Benefit Option Name: _____

1b) *Unique Benefit Option Identifier: _____

1c) *Benefit Option Type: Self-Funded _____ Insured _____ Both _____

1d) *Benefit Administrator Company Name: _____

C. *Programs and Procedures for Chronic and High-Cost Conditions

~~Please identify the chronic and high-cost conditions for which the employment-based plan has implemented programs and procedures to generate cost savings with respect to participants with those conditions. Please summarize the programs and procedures.~~A sponsor cannot participate in the Early Retiree Reinsurance Program unless, as of the date of its application for the program is submitted, its employment-based plan has in place programs and procedures that have generated or have the potential to generate cost savings with respect to plan participants with chronic and high cost conditions. The program regulations define "chronic and high cost condition" as a condition for which $15,000 or more in health benefit claims are likely to be incurred during a plan year by one plan participant. Please identify the chronic and high cost conditions for which the employment-based plan has such programs and procedures in place, and summarize those programs and procedures, including how it was determined that the identified conditions satisfy the $15,000 threshold. If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

D. *Estimated Amount of Early Retiree Reinsurance Program Reimbursements

Please estimate the projected amount of proceeds you expect to receive under the Early Retiree Reinsurance Program for the plan identified in this application, for each of the first two plan year cycles identified in this application. ~~For this purpose~~If you wish, you may provide a range of expected program proceeds that includes: (1) a low-end estimate of expected program proceeds, (2) an estimate that represents your most likely amount of program proceeds, and (3) a high-end estimate of expected

program proceeds. For purposes of this estimate only, please assume for each of those plan year cycles that there will be sufficient program funds to cover all claims submitted by the Plan Sponsor that comply with program requirements~~, although this might not be the case.~~. If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

E. *Intended Use of Early Retiree Reinsurance Program Reimbursements

1) ~~*~~Please summarize how your organization will use ~~proceeds~~the reimbursement under the Early Retiree Reinsurance Program to reduce health benefit or health benefit premium costs for the sponsor of the employment-based plan~~;~~ (i.e., to offset increases in such costs); or reduce premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs (or combination of these) for plan participants; or reduce a combination of any of these costs (whether offsetting increases in sponsor costs or offsetting or reducing plan participants' costs). If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

~~*Please summarize how the Plan Sponsor will use program reimbursement to maintain its level of financial contribution to the employment-based plan.~~

2) If a sponsor decides to apply the reimbursement for its own use, it may only use the reimbursement to offset increases in its health benefit premium costs, if an insured plan, or its health benefit costs, if it is self-funded. If any amount of the reimbursement is used to offset increases in health benefit premium or health benefit costs of your organization (as opposed to offsetting increases to, or reducing, plan participants' costs), please summarize how program funds, as a result of being used by your organization for such purposes, will relieve your organization of using its own funds to subsidize such increases, thereby allowing your organization to instead use its own funds to maintain its level of financial contribution to the employment-based plan. (In other words, please explain how your organization will continue to maintain the level of support for this plan, and if it applies the reimbursement for its own use, will use the program reimbursement to pay for increases in health benefit premium costs or health benefit costs, as applicable). If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

PART III: Banking Information for Electronic Funds Transfer

1) *Bank Name: _____

2) *Bank Address:

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

3) *Account Number: _____

4) *Name of Organization Associated with Account: _____

5) *Account type: (Checking or Savings Account) _____

6) *Bank Routing Number: _____

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

8) *Email address: _____

9) *Telephone Number: _____

PART IV. Plan Sponsor Agreement

1.	**Compliance:** In order to receive program reimbursement(s), Plan Sponsor agrees to comply with all of the terms and conditions of Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 ~~CFR~~ C.F.R. Part 149 and in other guidance issued by ~~HHS,~~the Secretary of the U.S. Department of Health & Human Services (the Secretary), including, but not limited to, the conditions for submission of data for obtaining reimbursement and the record retention requirements.
2.	**Reimbursement-Related and Other Representations Made by Designees:** Plan Sponsor may be given the opportunity to identify one or more Designees (i.e., individuals the Sponsor will authorize to perform certain functions on behalf of the Sponsor related to the Early Retiree Reinsurance Program, such as individual(s) who will be involved in making program reimbursement requests). Plan Sponsor certifies that all individuals that will be identified as Designees ~~in this Application, including, but not limited to, Reimbursement Requesters,~~will have first been given authority by the Plan Sponsor to perform those respective functions on behalf of the Plan Sponsor. Plan Sponsor understands that it is bound by any representations such individuals make with respect to the Sponsor's involvement in the Early Retiree Reinsurance ~~program~~Program, including but not limited to the Sponsor's ~~application for, participation in, and~~ reimbursement under, the ~~Program~~program.
3.	**Written Agreement:** Plan Sponsor certifies that, prior to submitting a Reimbursement Request, it has executed a written agreement with its health insurance issuer or ~~group health~~employment-based plan regarding disclosure of information, data, documents, and records to HHS, and the issuer or plan agrees to disclose to HHS, on behalf of the Plan Sponsor, at a time and in a manner specified by the HHS Secretary in guidance, the information, data, documents, and records necessary for the Plan Sponsor to comply with the requirements of the Early Retiree Reinsurance Program~~.~~, as specified in 45 C.F.R. 149.35.
4.	**Use of Records:** Plan Sponsor understands and agrees that ~~officers, employees and contractors of the Department of Health and Human Services~~the Secretary may use data and information collected under the Early Retiree Reinsurance Program only for the purposes of, and to the extent necessary in, carrying out ~~their responsibilities under~~ Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 ~~CFR~~C.F.R. Part 149 including, but not limited to, ~~determination of~~determining reimbursements and reimbursement-related oversight and program integrity activities, or as otherwise ~~required~~allowed by law. Nothing in this section limits the U.S. Department of Health & Human Services' Office of the Inspector General's ~~(OIG)~~ authority to fulfill the ~~OIG's~~Inspector General's responsibilities in accordance with applicable Federal law.
5.	**Obtaining Federal Funds:** Plan Sponsor acknowledges that the information furnished in its Plan Sponsor application is being provided to obtain Federal funds. Plan Sponsor certifies that it requires all subcontractors, including plan administrators, to acknowledge that information provided in connection with ~~the~~a subcontract is used for purposes of obtaining Federal funds. Plan Sponsor acknowledges that reimbursement of program funds is conditioned on the submission of accurate information. Plan Sponsor agrees that it will not knowingly present or cause to be presented a false or fraudulent claim. Plan Sponsor acknowledges that any excess reimbursement made to the Plan Sponsor under the Early Retiree Reinsurance Program, or any debt that arises from such excess reimbursement, may be recovered by ~~HHS.~~the Secretary. Plan

	Sponsor will promptly update any changes to the information submitted in its Plan Sponsor application. 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 ~~HHS~~the Secretary promptly of this fact.
6.	**Data Security:** Plan Sponsor agrees to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this Plan Sponsor application. Plan Sponsor 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. Plan Sponsor certifies that its employment-based plan(s) has established and implemented appropriate safeguards in compliance with 45 ~~CFR~~C.F.R. Parts 160~~, 162~~ and 164 (HIPAA administrative simplification, privacy and security rule) in order to prevent unauthorized use or disclosure of such information ~~or data~~. Sponsor also agrees that if it participates in the administration of the plan(s), then it has also established and implemented ~~the same~~appropriate safeguards in ~~compliance with the above HIPAA citations.~~regard to PHI. Any and all Plan Sponsor personnel interacting with PHI 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:** Plan Sponsor hereby authorizes ~~HHS~~ the Secretary to initiate reimbursement, credit entries and other adjustments, including offsets and requests for reimbursement, in accordance with the provisions of Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 ~~CFR~~C.F.R Part 149 and applicable provisions of 45 ~~CFR~~C.F.R. Part 30, to the account at the financial institution (hereinafter the "Depository") indicated under the Electronic Funds Transfer (EFT) section of the Plan Sponsor application. Plan Sponsor agrees to immediately pay back any excess reimbursement or debt upon notification from ~~HHS~~the Secretary of the excess reimbursement or debt. Plan Sponsor agrees to promptly update any changes in its Depository information.
8.	**Policies and Procedures to Detect Fraud, Waste and Abuse**. The Plan Sponsor attests that, as of the date this Application is submitted, has in place policies and procedures to detect and reduce fraud, waste, and abuse related to the Early Retiree Reinsurance Program. The Plan Sponsor will produce the policies and procedures, and necessary information, records and data, upon request by the Secretary, to substantiate existence of the policies and procedures and their effectiveness, as specified in 45 C.F.R. Part 149.
~~8.~~9.	**Change of Ownership:** The Plan Sponsor shall provide written notice to ~~HHS~~the Secretary at least 60 days prior to a change in ownership, as defined in 45 ~~CFR Part~~C.F.R. 149.700. When a change of ownership results in a transfer of the liability for health benefits 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.
	Signature of Plan Sponsor Authorized Representative I, the undersigned Authorized Representative of Plan Sponsor, declare that I have legal authority to sign and bind the Plan Sponsor to the terms of this Plan Sponsor Agreement, and I have or will provide evidence of such authority. I 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~~statutes, regulations, and other guidance applicable to the Early Retiree Reinsurance

	Program ~~(~~including, but not limited to Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 ~~CFR~~C.F.R. Part 149 and applicable provisions of 45 ~~CFR~~C.F.R. Part 30 and all other applicable ~~laws~~statutes 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 ~~HHS~~the Secretary to verify this information. I understand that, because program reimbursement 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

Attachment: Additional Benefit Options

(Complete this form for each unique benefit option)

1a) *Benefit Option Name: _____

1b) *Unique Benefit Option Identifier: _____

1c) *Benefit Option Type: Self-Funded _____ Insured _____ Both _____

1d) *Benefit Administrator Company Name: _____