

## Health Plan Administrators, Inc. 2008 Overseas Travel Medical List Bill Form

This is not an employer-sponsored plan: neither the employee nor the employer can treat or represent the premiums as part of an employer-sponsored health insurance program for the purpose of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

Complete the following for a monthly list billing. Please attach the Individual Applications, a Temporary Insurance Acknowledgement Form signed by each applicant participating in the list billing, and a check for the first month's premiums / fees due. List the requested effective date here (The same day of the month will apply to all applicants included on this list bill): \_\_\_\_\_. **Payments are due on the same day as selected each month.** Premiums must be paid within the plans stated provision for premium payments, or the STM coverage will terminate.

AUTHORIZED BY: \_\_\_\_\_ Company Title: \_\_\_\_\_ Date: \_\_\_\_\_  
 Bill to: \_\_\_\_\_ Billing Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Overseas Travel STM Multiple Applicants Enrollment Form:		Effective Date	Departure Date	Date Returning to Home Country				
Mail Confirmation and ID Cards To:			Plan Selected	Coverage Max \$				
Agent Name:		HPA Code #		Telephone #		Deductible Choice \$		
Applicant Name	Date of Birth	Age	Sex	Passport #	Beneficiary Name	Home Country	Country To Visit	Premium
Payment By: Check	Credit Card #:	Exp Date _____		Type: Master card _____	Visa _____	Discover _____		
Name on Card:	Authorized Signature			Date	Total Premium _____			



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**THIRD PARTY PAYOR'S ACCEPTANCE OF PAYROLL DEDUCTION PLAN**

*Administered by: Health Plan Administrators*

**Select Product:**

- |                                |                          |                          |                          |
|--------------------------------|--------------------------|--------------------------|--------------------------|
| <b>Short Term Medical</b>      | <input type="checkbox"/> | <b>Individual Dental</b> | <input type="checkbox"/> |
| <b>12x3 Short Term</b>         | <input type="checkbox"/> | <b>OTM</b>               | <input type="checkbox"/> |
| <b>Lite Short Term Medical</b> | <input type="checkbox"/> | <b>RX</b>                | <input type="checkbox"/> |

**This is an important agreement.  
You should read it carefully and understand it before signing below.**

The following guidelines must be agreed to for the set-up of the List Billing option for the plan selected above. The Third Party Payor understands and agrees:

- 1) To participate in this List Bill/Payroll Deduction arrangement for the convenience of our employees only and that we will honor the List Bill Election forms signed by our employees for Association Dues (where applicable), Administration fees, Rates and Premiums for Insurance. Our acceptance of this Payroll Deduction Plan is not contingent upon the eligibility requirements being made by the Insurance Company or Administrator.
- 2) To submit, monthly, as billed, any premiums, rates and fees due as indicated on the monthly List Billing Statement under Total Payment Due by the payment due date.
- 3) That it will not make any contribution to any portion of the Applicant's payments or make any reimbursements for payment to the Applicant through wage adjustment or other method, nor will the insurance plan be treated by us as part of a plan or program for the purpose of our taking a deduction for such payment under Sections 106, 125, or 162 (except 162(1)) of the Internal Revenue Code.
- 4) That the insurance applied for by the Applicants is neither intended nor anticipated to be an employer sponsored insurance plan as defined by state and/or federal law and this List Bill/Payroll Deduction plan is being offered only for the insured's convenience. Further we understand that each applicant's eligibility will be individually reviewed and a Certificate of Insurance issued on that basis, and that we may not obtain information relating to any Applicant's insurance coverage other than the amount of the applicant's payment due as part of this List Bill/Payroll Deduction Plan.
- 5) Billing will start following the first of the month after receipt and approval of the initial participant's application.
- 6) That it has no obligation (other than stated herein), and assumes no responsibility for submitting payments for Applicants after their eligibility for the List Bill option payment ceases.
- 7) That it, the Insurance Company, or the Administrator, upon giving 30-day prior written notice to the other and the affected Applicant(s), may terminate the List Billing Agreement. In the event the List Billing Agreement is terminated, the Applicant may continue coverage by sending future payments directly to the Company as stated in the statement signed by the Applicant pursuant to participation in this agreement.
- 8) That changes or adjustments to the amount of the List Bill administration fee or other terms of this agreement may occur upon 30-day prior written notice to the Third Party.
- 9) Any premium refunds that may be due will not be sent to the Applicant directly, but rather will be credited to the Third Party List Bill account.

X \_\_\_\_\_ X \_\_\_\_\_  
Applicant Name Third Party Name

X \_\_\_\_\_  
Applicant Signature Date