__ MP Employer
__ Self Employed
__ MP Direct

MEMPHIS Plan Enrollment Agreement

This agreement is between Church Health ("MEMPHIS Plan office") and _____ as of _____ ("Contract Date").

MEMPHIS Plan agrees to:

1. Accept participants into membership following submission of completed Applications. All participants must meet the eligibility criteria stated below.
2. Continue coverage on participants that maintain compliance with the MEMPHIS Plan guidelines and where the fees have been submitted to the MEMPHIS Plan. Termination due to non-compliance with these guidelines is at the sole discretion of the MEMPHIS Plan.

The Employer agrees to:

1. Offer the plan to only eligible employees, where "eligible" means he/she
   a. Earns no more than the maximum family annual income of 200% ($27,180 for 1 person) of the federal poverty level depending on the household size
   b. Works at least 20 hours a week
   c. Participant must not be enrolled in Medicaid or other private insurance
   d. Employer must have less than 200 eligible employees and have a physical address in Tennessee

The Self Employed or MP Direct (enroll independently) participant agrees to:

   a. Earn no more than the maximum family annual income of 200% ($27,180 for 1 person) of the federal poverty level depending on the household size
   b. Work at least 20 hours a week and resides in Tennessee
   c. Not be enrolled in Medicaid or other private insurance
   d. Provide annual 1040 tax return; Self-Employed must provide Schedule C along with 1040 tax return

2. Submit any account or coverage changes (terminations, enrollments, and invoice corrections) by the Monthly Cut-off Date (the last business day of the month) in order for the changes to be reflected on the next invoicing period.
   a. Completed Applications received by the Monthly Cut-off Date will result in coverage effective the first day of the second month following application submission.
3. Notify the MEMPHIS Plan office of any participants who are no longer eligible for the plan. Ineligibility may result from employment termination, increase in hourly wage over the plan's maximum, decrease in work hours below the plan's minimum amount required, pregnancy or obtainment of other health coverage.
   a. Terminations must be submitted to the MEMPHIS Plan office using the termination form supplied in the welcome packet. Terminations will be effective the first of the month after the termination form is received by the MEMPHIS Plan office.
4. As an Employer contribute at least $10 of the monthly fee for each employee and collect all remaining amounts from the participant.
5. Remit 100% of the monthly subscription fees to the MEMPHIS Plan Remittance Office no later than ten days after the invoice date.
6. Self-Employed and MP Direct enrollees must execute an Authorization Agreement for Pre-Authorization Payment of monthly fees.
7. Employers must notify the MEMPHIS Plan office if the number of eligible employees (as defined in paragraph 1 above for employer agrees to) exceeds 200, at which time the employer is no longer eligible to offer the MEMPHIS Plan to employees.

Duration of Agreement:

This agreement will remain in continuous effect from the Contract Date until cancelled by:

1. The Employer, Self Employed or MP Direct Participant by giving at least 30-day written notice to the MEMPHIS Plan,
2. Church Health giving at least 30-day written notice to the Employer/Self Employed/MP Direct, or
3. Church Health for non-payment of monthly fees.

For Employers Certification Only
Total Number of Employees: _____

Total # of Employees Eligible for
MEMPHIS Plan _____

I agree to the conditions stated and certify that this information is correct to the best of my knowledge and that no one is enrolled who is not eligible as described in this Enrollment Agreement. I certify that each eligible participant has been contacted and offered the opportunity to enroll.

Signature: _____Date: _____

Please Print:

Employer/SE/MP Direct Name: _____ DBA: _____

Physical Address: _____
street city state zip

Mailing Address: _____
street city state zip

Phone: (____) _____ Fax: (____) _____

Contact Name _____ Email: _____

How did you find out about the MEMPHIS Plan? _____

MEMPHIS Plan Office Use Only:
MEMPHIS Plan Staff Signature: _____ Date: _____

SIC: _____ ACH _____ # of Locations _____ Employee Effective Date: _____

# of Participants Enrolled _____# of Dependents Enrolled _____