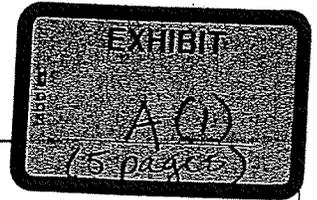


Massachusetts Application for Transitional Individual Producer License

Go to www.state.ma.us/doj for instructions
(Please Print or Type)



① Soc Security Number [REDACTED] ② If assigned, National Producer Number (NP#)
 ③ If applicable, NASD Individual Central Registration Depository (CRD) Number
 ④ Are you affiliated with a financial institution/bank?
 Yes No
 ⑤ Last Name Brettschneider JR /SR etc ⑥ First Name Jedediah ⑦ Middle Name L ⑧ Date of Birth (month) 01 (day) 07 (year) 76
 ⑨ Residence/Home Address (Physical Street) 69 Nourse St ⑩ P O Box ⑪ City Westborough ⑫ State MA ⑬ Zip or Foreign Country 01581
 ⑭ Home Phone Number (508) 898-0405 ⑮ Gender (Circle One) Male Female ⑯ Are you a Citizen of the United States? (Check One) Yes No (If No, of which country are you a citizen?) (If No, you must supply work authorization)
 ⑰ Employer's Name Jed Brett Schneider
 ⑱ Business Address (Physical Street) 69 Nourse St ⑲ P O Box ⑳ City Westboro ㉑ State MA ㉒ Zip or Foreign Country 01581
 ㉓ Business Phone Number (508) 380 6811 ㉔ Business Fax Number 617 299 0277 ㉕ Business E-Mail Address ㉖ Business Web Site Address
 ㉗ Applicant's Mailing Address 69 Nourse St ㉘ P O Box ㉙ City Westboro ㉚ State MA ㉛ Zip or Foreign Country 01581
 ㉜ List any name under which you are doing business

Agency or Business Entity Affiliations

㉝ List your Insurance Agency Affiliations (Complete only if the applicant is to be licensed as an active member of the business entity)
 FEIN _____ NP # _____ Name of Agency _____
 FEIN _____ NP # _____ Name of Agency _____
 FEIN _____ NP # _____ Name of Agency _____
 FEIN _____ NP # _____ Name of Agency _____

Employment History

㉞ Account for all time for the past five years. Give all employment experience starting with your current employer working back five years. Include full and part-time work, self-employment, military service, unemployment and full-time education

Name	City	State	From		To		Position Held
			Month	Year	Month	Year	
<u>Jed Brett Schneider</u>	<u>Westborough</u>	<u>MA</u>	<u>4</u>	<u>02</u>	<u>5</u>	<u>03</u>	<u>Agent</u>
<u>CKW Technologies</u>	<u>Westborough</u>		<u>1</u>	<u>96</u>	<u>4</u>	<u>02</u>	<u>Customer Relations</u>
Name	City	State					
Name	City	State					
Name	City	State					

Background Information

36 The Applicant must read the following very carefully and answer every question. All copies of documents must be certified. All written statements submitted by the Applicant must include an original signature.

1. Have you ever been convicted of, or are you currently charged with, committing a crime, whether or not adjudication was withheld? Yes ___ No ___

"Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

If you answer yes, you must attach to this application:

- a) a written statement explaining the circumstances of each incident.
b) a certified copy of the charging document, and
c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

2. Have you or any business in which you are or were an owner, partner, officer or director ever been involved in an administrative proceeding regarding any professional or occupational license? Yes ___ No ___

"Involved" means having a license censured, suspended, revoked, canceled, terminated or, being assessed a fine, placed on probation or surrendering a license to resolve an administrative action. "Involved" also means being named as a party to an administrative or arbitration proceeding which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may exclude terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

- a) a written statement identifying the type of license and explaining the circumstances of each incident.
b) a certified copy of the Notice of Hearing or other document that states the charges and allegations, and
c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has any demand been made or judgment rendered against you for overdue monies by an insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding? Yes ___ No ___

If you answer yes, submit a statement summarizing the details of the indebtedness and arrangements for repayment, and/or type and location of bankruptcy.

4. Have you been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement? Yes ___ No ___

If you answer yes, identify the jurisdiction(s) _____

5. Are you currently a party to, or have you ever been found liable in, any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty? Yes ___ No ___

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident.
b) a certified copy of the Petition, Complaint or other document that commenced the lawsuit or arbitration, and
c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

6. Have you or any business in which you are or were an owner, partner, officer or director ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes ___ No ___

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
b) certified copies of all relevant documents.

7. Do you have a child support obligation in arrearage? Yes ___ No ___

If you answer yes to Question 7, by how many months are you in arrearage? _____ Months

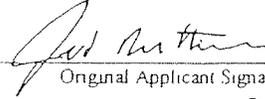
8. Are you the subject of a child support related subpoena or warrant? Yes ___ No ___

Applicants Certification and Attestation

37 The Applicant must read the following very carefully

- 1 I hereby certify that under penalty of perjury, all of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license revocation or denial of the license and may subject me to civil or criminal penalties
- 2 Where required by law, I hereby designate the Commissioner, Director or Superintendent of Insurance, or other appropriate party in each jurisdiction for which this application is made to be my agent for service of process regarding all insurance matters in the respective jurisdiction and agree that service upon the Commissioner, Director or Superintendent of Insurance, or other appropriate party of that jurisdiction is of the same legal force and validity as personal service upon myself
- 3 I further certify that I grant permission to the Commissioner, Director or Superintendent of Insurance, or other appropriate party in each jurisdiction for which this application is made to verify information with any federal, state or local government agency, current or former employer or insurance company
- 4 I further certify that, under penalty of perjury, either a) I have no child-support obligation, or b) I have a child-support obligation and I am currently in compliance with that obligation
- 5 I authorize the jurisdictions to give any information concerning me, as permitted by law, to any federal, state or municipal agency or any other organization and I release the jurisdictions and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information
- 6 I acknowledge that I understand and will comply with the insurance laws and regulations of the jurisdictions to which I am applying for licensure
- 7 I certify that I am licensed and in good standing in my home state/resident state for the lines of authority requested from the non-resident state

4 23 03
Month Day Year



Original Applicant Signature

Jedediah Brettschneider

Full Legal Name (Printed or Typed)

Attachments

38 The following attachments must accompany the application otherwise the application may be returned unprocessed or considered deficient

- 1 Massachusetts will rely on an electronic verification of an applicant's resident license through the NAIC's Producer Database in lieu of requiring an original Letter of Certification from the resident state
- 2 See www.state.ma.us/doi for specific attachments and instructions

Mail this application and a check made payable to the Commonwealth of Massachusetts (see enclosed License Application Notice for Total Fee Due) to the address below. In order to allow sufficient processing time, please return the application to the DOI by June 16, 2003. Do not mail the application to the DOI's office address, as this will delay processing

Division of Insurance - Producer Licenses
P.O. Box 370043
Boston, Massachusetts 02241-1743



JEDEDIAH BRETTSCHEIDER
69 NOURSE ST.
WESTBOROUGH, MA 01581

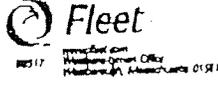
5-13/110

321

DATE 4.23.03

PAY TO THE ORDER OF Commonwealth of MA \$ 200.00

Two hundred dollars exactly DOLLARS



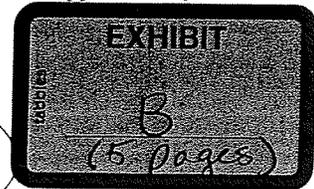
MEMO

[Signature]

Please note the application may be revised on a semi-annual basis. To ensure you are filing the current version of the application, please reference the National Insurance Producer Registry web site at www.licenseregistry.com.

Uniform Application for Individual Insurance Producer License

(Please Print or Type)



DIVISION OF INSURANCE
PRODUCTION LICENSING
JAN 17 2005
PROCESSED
256

Check appropriate box for license requested.

- Resident License
- Non-Resident License
- Identify Home State: Massachusetts
- Identify Home State License #: 1769859

① Soc. Security Number <div style="background-color: black; width: 100px; height: 15px;"></div>		② If assigned, National Producer Number (NPN) 7268758	
③ If applicable, NASD Individual Central Registration Depository (CRD) Number		④ Are you affiliated with a financial institution/bank? Yes <input type="checkbox"/> No <input type="checkbox"/>	
⑤ Last Name JR /SR etc Brettschneider		⑥ First Name Jed	⑦ Middle Name L.
⑧ Date of Birth (month) <u>1</u> (day) <u>7</u> (year) 1976			
⑨ Residence/Home Address (Physical Street) 69 Nourse Street		⑩ P.O. Box	⑪ City Westborough
	⑫ State MA	⑬ Zip Code 01581	⑭ Foreign Country
⑮ Home Phone Number (617) 645 - 9000		⑯ Gender (Circle One) Male <input checked="" type="radio"/> Female <input type="radio"/>	⑰ Are you a Citizen of the United States? (Check One) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If No, of which country are you a citizen?) (If No, you must supply work authorization.)
⑱ Business Entity Name New England Custom Health Plan Administrators, LLC			
⑲ Business Address (Physical Street) 7 Wells Avenue, Suite 24		⑳ P.O. Box	㉑ City Newton
	㉒ State MA	㉓ Zip Code 02459	㉔ Foreign Country
㉕ Business Phone Number (617) 581 - 6655		㉖ Business Fax Number (617) 249-0217	㉗ Business E-Mail Address jbrett@atadirect.com
㉘ Business Web Site Address www.atadirect.com			
㉙ Applicant's Mailing Address 7 Wells Avenue, Suite 24		㉚ P.O. Box	㉛ City Newton
	㉜ State MA	㉝ Zip Code 02459	㉞ Foreign Country
㉟ List any other assumed, fictitious, alias, maiden or trade names under which you have used in the past to do business, are currently doing business or intend to do business. ATA Direct			

Agency or Business Entity Affiliations

㊱ List your Insurance Agency Affiliations: (Complete only if the applicant is to be licensed as an active member of the business entity)

20-1308264		New England Custom Health Plan Administrators, LLC
FEIN _____	NPN _____	Name of Agency _____
FEIN _____	NPN _____	Name of Agency _____
FEIN _____	NPN _____	Name of Agency _____

Employment History

㊲ Account for all time for the past five years. Give all employment experience starting with your current employer working back five years. Include full and part-time work, self-employment, military service, unemployment and full-time education.

Name	From		To		Position Held
	Month	Year	Month	Year	
New England Custom Health Plan Administrators, LLC	Jul	2004			President
City <u>Newton</u> State <u>MA</u> Foreign Country _____					
Name _____					
City _____ State _____ Foreign Country _____					
Name _____					
City _____ State _____ Foreign Country _____					
Name _____					
City _____ State _____ Foreign Country _____					

(State Use)

Please note the application may be revised on a semi-annual basis. To ensure you are filing the current version of the application, please reference the National Insurance Producer Registry web site at www.licenseregistry.com.

Jurisdiction and Type of License Requested

38 Next to each jurisdiction, check the license type(s) and line(s) of authority for which you are applying

License Types: A - Agent B - Broker P - Producer SLP - Surplus Lines Producer
 Lines of Authority: V - Variable Life/Variable Annuity L - Life H - Accident & Health or Sickness P - Property C - Casualty PL - Personal Lines
 Limited Lines: Credit - Credit CR - Car Rental CROP - Crop T - Travel S - Surety O - Other

Jurisdiction	License Type				Major Lines of Authority						Limited Lines of Authority					
	A	B	P	SLP	V	L	H	P	C	PL	Credit	CR	CROP	T	S	O
AK																
AL																
AR																
AZ																
CA																
CO																
CT																
DC																
DE																
FL																
GA																
GU																
HI																
IA																
ID																
IL																
IN																
KS																
KY																
LA																
MA			X			X	X									
MD																
ME																
MI																
MN																
MO																
MS																
MT																
NC																
ND																
NE																
NH																
NJ																
NM																
NV																
NY																
OH																
OK																
OR																
PA																
PR																
RI																
SC																
SD																
TN																
TX																
UT																
VI																
VA																
VT																
WA																
WI																
WV																
WY																

Background Information

39) The Applicant must read the following very carefully and answer every question. All copies of documents must be certified. All written statements submitted by the Applicant must include an original signature.

1. Have you ever been convicted of, or are you currently charged with, committing a crime, whether or not adjudication was withheld? Yes ___ No X

"Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses.
"Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

If you have a felony conviction, have you applied for a waiver as required by 18 USC 1033? N/A ___ Yes ___ No ___

If so, was that waiver granted? (Attach copy of 1033 waiver approved by home state) N/A ___ Yes ___ No ___

If you answer yes, you must attach to this application:

- a) a written statement explaining the circumstances of each incident,
- b) a certified copy of the charging document, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

2. Have you or any business in which you are or were an owner, partner, officer or director ever been involved in an administrative proceeding regarding any professional or occupational license? Yes ___ No X

"Involved" means having a license censured, suspended, revoked, canceled, terminated; or, being assessed a fine, placed on probation or surrendering a license to resolve an administrative action. "Involved" also means being named as a party to an administrative or arbitration proceeding which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may exclude terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

- a) a written statement identifying the type of license and explaining the circumstances of each incident,
- b) a certified copy of the Notice of Hearing or other document that states the charges and allegations, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has any demand been made or judgment rendered against you for overdue monies by an insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding? Yes ___ No X

If you answer yes, submit a statement summarizing the details of the indebtedness and arrangements for repayment, and/or type and location of bankruptcy.

4. Have you been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement? Yes ___ No X

If you answer yes, identify the jurisdiction(s): _____

5. Are you currently a party to, or have you ever been found liable in, any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty? Yes ___ No X

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident,
- b) a certified copy of the Petition, Complaint or other document that commenced the lawsuit or arbitration, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

6. Have you or any business in which you are or were an owner, partner, officer or director ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes ___ No X

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
- b) certified copies of all relevant documents.

7. Do you have a child support obligation in arrearage? Yes ___ No X

If you answer yes to Question 7, by how many months are you in arrearage? _____ Months

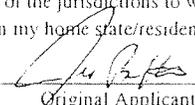
8. Are you the subject of a child support related subpoena or warrant? Yes ___ No X

Applicants Certification and Attestation

40 The Applicant must read the following very carefully:

- 1 I hereby certify that, under penalty of perjury, all of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license revocation or denial of the license and may subject me to civil or criminal penalties.
- 2 Where required by law, I hereby designate the Commissioner, Director or Superintendent of Insurance, or other appropriate party in each jurisdiction for which this application is made to be my agent for service of process regarding all insurance matters in the respective jurisdiction and agree that service upon the Commissioner, Director or Superintendent of Insurance, or other appropriate party of that jurisdiction is of the same legal force and validity as personal service upon myself.
- 3 I further certify that I grant permission to the Commissioner, Director or Superintendent of Insurance, or other appropriate party in each jurisdiction for which this application is made to verify information with any federal, state or local government agency, current or former employer, or insurance company.
- 4 I further certify that, under penalty of perjury, either a) I have no child-support obligation, or b) I have a child-support obligation and I am currently in compliance with that obligation.
- 5 I authorize the jurisdictions to give any information concerning me, as permitted by law, to any federal, state or municipal agency, or any other organization and I release the jurisdictions and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information.
- 6 I acknowledge that I understand and will comply with the insurance laws and regulations of the jurisdictions to which I am applying for licensure.
- 7 For Non-Resident License Applications, I certify that I am licensed and in good standing in my home state/resident state for the lines of authority requested from the non-resident state.

1 / 4 / 06
 Month Day Year


 Original Applicant Signature

Jed L. Brettschneider

Full Legal Name (Printed or Typed)

Attachments

- 41 The following attachments must accompany the application otherwise the application may be returned unprocessed or considered deficient:
 - 1 For Non-Resident License Applications and unless otherwise noted in the State Matrix of Business Rules, a state will rely on an electronic verification of an applicant's resident license through the NAIC's Producer Database in lieu of requiring an original Letter of Certification from the resident state.
 - 2 Any jurisdiction specific attachments listed in the State Matrix of Business Rules (www.licenseregistry.com)

NEW ENGLAND CUSTOM HEALTH
PLAN ADMINISTRATORS, LLC
275 GROVE STREET
NEWTON, MA 02466



5-13/110

1256

1/4/2006

PAY TO THE
ORDER OF Commonwealth of MA

\$ ••225.00

Two Hundred Twenty-Five and 00/100

DOLLARS

Commonwealth of MA



Janet Brattin

MEMO:



Security Features: Details on back.

Bank of America



Batch:
8317096

LOCKBOX	BATCH	ITEM	IMAGE	DATE	AMOUNT
370043	3	14	14	January 10, 2006	\$ 225.00
BOSTON	SITE				

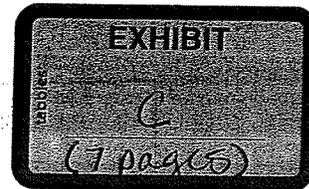
Please note the application may be revised on a semi-annual basis. To ensure you are filing the current version of the application and that the application is complete, please reference the National Insurance Producer Registry web site at www.licenseregistry.com.

**Uniform Application for
Business Entity Insurance License/Registration**
(Please Print or Type)

Check appropriate box for license requested.

- Resident License
- Non-Resident License
 - Identify Home State: Massachusetts
 - Identify Home State License #: 1797789

DIVISION OF
PRODUCER REGISTRATION
PROCESSED



① Business Entity Name New England Custom Health Plan Administrators, LLC		② Incorporation/Formation Date June 1, 2004		③ FEIN 20 - 1308264	
④ If assigned, National Producer Number (NP#)			⑤ If applicable, NASD Firm Central Registration Depository (CRD) Number		
⑥ List any other assumed, fictitious, alias or trade names under which you are doing business or intend to do business ATA Direct		⑦ State of Domicile MA		⑧ Country of Domicile USA	
⑨ Is the business entity affiliated with a financial institution/bank? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
⑩ Business Address 7 Wells Avenue - Suite 24		⑪ City Newton	⑫ State MA	⑬ Zip Code 02459	⑭ Foreign Country
⑮ Phone Number (617) 581-6655	⑯ Fax Number (617) 249-0217	⑰ Business Web Site Address www.atadirect.com		⑱ Business E-Mail Address jbrett@atadirect.com	
⑲ Mailing Address 7 Wells Avenue - Suite 24		⑳ P O Box	㉑ City Newton	㉒ State MA	㉓ Zip Code 02459

Designated/Responsible Licensed Producer

25 Identify at least one Designated/Responsible Licensed Producer (See Matrix of State Requirements at www.licenseregistry.com for jurisdictions that require the designated/responsible licensed producer to be an officer, director or partner of the business entity)

Name Jed L. Brettschneider SSN [REDACTED]

Name Michael A. Cassandro SSN [REDACTED]

Name _____ SSN - -

Name _____ SSN - -

Owners, Partners, Officers and Directors

26 Identify all owners with 10% interest or voting interest, partners, officers and directors of the business entity:

Name Jed Brettschneider Title President & CEO SSN/FEIN [REDACTED] Owner: Yes / No

Name Michael A. Cassandro Title Regional Director SSN/FEIN [REDACTED] Owner: Yes / No

Name _____ Title _____ SSN/FEIN - - Owner: Yes / No

Name _____ Title _____ SSN/FEIN - - Owner: Yes / No

Name _____ Title _____ SSN/FEIN - - Owner: Yes / No

Name _____ Title _____ SSN/FEIN - - Owner: Yes / No

Name _____ Title _____ SSN/FEIN - - Owner: Yes / No

Name _____ Title _____ SSN/FEIN - - Owner: Yes / No

(State Use)

Please note the application may be revised on a semi-annual basis. To ensure you are filing the current version of the application and that the application is complete, please reference the National Insurance Producer Registry web site at www.licenseregistry.com.

Jurisdiction and Type of License Registration Requested –Major Lines of Authority

Next to each jurisdiction, check the legal business type, license registration type(s) and line(s) of authority for which you are applying.

Legal Business Type: C - Corporation P - Partnership S - Sole Proprietorship LLC - Limited Liability Company LLP - Limited Liability Partnership
 License/Registration Types: A - Agent B - Broker P - Producer SLP - Surplus Lines Producer Y - Business Entity
 Lines of Authority: V - Variable Life/Variable Annuity L - Life H - Health & Health Care P - Property C - Casualty PL - Personal Lines

Jurisdiction	Legal Business Type					License Registration Type					Lines of Authority					
	C	P	S	LLC	LLP	A	B	P	SLP	Y	V	L	H	P	C	PL
AK																
AL																
AR																
AZ																
CA																
CO																
CT																
DC																
DE																
FL																
GA																
GU																
HI																
IA																
ID																
IL																
IN																
KS																
KY																
LA																
MA																
MD																
ME																
MI																
MN																
MO																
MS																
MT																
NC																
ND																
NE																
NH																
NJ																
NM																
NV																
NY																
OH																
OK																
OR																
PA																
PR																
RI																
SC																
SD																
TN																
TX																
UT																
VA																
VI																
VT																
WA																
WI																
WV																
WY																

Jurisdiction and Type of License/Registration - Limited Lines of Authority

28) Next to each jurisdiction, check the legal business type, license/registration type(s) and line(s) of authority for which you are applying.

Legal Business Type: C - Corporation P - Partnership S - Sole Proprietorship LLC - Limited Liability Company LLP - Limited Liability Partnership
 License/Registration Types: A - Agent B - Broker P - Producer SLP - Surplus Lines Producer Y - Business Entity
 Limited Lines: Credit - Credit CR - Casualty CROP - Crop T - Travel S - Surety O - Other

Jurisdiction	Legal Business Type					License/Registration Type					Lines of Authority					
	C	P	S	LLC	LLP	A	B	P	SLP	Y	Credit	CR	Crop	T	S	O
AK																
AL																
AR																
AZ																
CA																
CO																
CT																
DC																
DE																
FL																
GA																
GU																
HI																
IA																
ID																
IL																
IN																
KS																
KY																
LA																
MA																
MD																
ME																
MI																
MN																
MO																
MS																
MT																
NC																
ND																
NE																
NH																
NJ																
NM																
NV																
NY																
OH																
OK																
OR																
PA																
PR																
RI																
SC																
SD																
TN																
TX																
UT																
VA																
VI																
VT																
WA																
WI																
WV																
WY																

Please note the application may be revised on a semi-annual basis. To ensure you are filing the current version of the application and that the application is complete, please reference the National Insurance Producer Registry web site at www.licenseregistry.com.

Background Information

29) Please read the following very carefully and answer every question. All copies of documents must be certified. All written statements submitted by the Applicant must include an original signature.

1. Has the business entity or any owner, partner, officer or director ever been convicted of, or is the business entity or any owner, partner, officer or director currently charged with, committing a crime, whether or not adjudication was withheld? Yes ___ No X

"Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

If you answer yes, you must attach to this application:

- a) a written statement explaining the circumstances of each incident,
- b) a certified copy of the charging document, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

2. Has the business entity or any owner, partner, officer or director ever been involved in an administrative proceeding regarding any professional or occupational license? Yes ___ No X

"Involved" means having a license censured, suspended, revoked, canceled, terminated, or being assessed a fine, placed on probation or surrendering a license to resolve an administrative action. "Involved" also means being named as a party to an administrative or arbitration proceeding which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may exclude terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

- a) a written statement identifying the type of license and explaining the circumstances of each incident,
- b) a certified copy of the Notice of Hearing or other document that states the charges and allegations, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has any demand been made or judgment rendered against the business entity or any owner, partner, officer or director for overdue monies by an insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding? Yes ___ No X

If you answer yes, submit a statement summarizing the details of the indebtedness and arrangements for repayment.

4. Has the business entity or any owner, partner, officer or director ever been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement? Yes ___ No X

If you answer yes, identify the jurisdiction(s): _____

5. Is the business entity or any owner, partner, officer or director a party to, or ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty? Yes ___ No X

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident,
- b) a certified copy of the Petition, Complaint or other document that commenced the lawsuit or arbitration, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

6. Has the business entity or any owner, partner, officer or director ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes ___ No X

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
- b) certified copies of all relevant documents.

Applicants Certification and Attestation

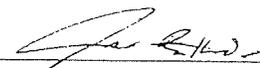
- 10 The undersigned owner, partner, officer or director of the business entity hereby certifies, under penalty of perjury, that:
1. All of the information submitted in this application and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me and the business entity to civil or criminal penalties
 2. Where required by law, the business entity hereby designates the Commissioner, Director or Superintendent of Insurance, or an appropriate representative in each jurisdiction for which this application is made to be its agent for service of process regarding all insurance matters in the respective jurisdiction and agree that service upon the Commissioner or Director of that jurisdiction is of the same legal force and validity as personal service upon the business entity
 3. The business entity grants permission to the Commissioner or Director of Insurance in each jurisdiction for which this application is made to verify any information supplied with any federal, state or local government agency, current or former employer or insurance company
 4. Every owner, partner, officer or director of the business entity either a) does not have a current child-support obligation, or b) has a child-support obligation and is currently in compliance with that obligation
 5. I authorize the jurisdictions to give any information they may have concerning me to any federal, state or municipal agency, or any other organization and I release the jurisdictions and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information
 6. I acknowledge that I understand and comply with the insurance laws and regulations of the jurisdictions to which I am applying for licensure/registration
 7. If required, I have received a Certificate of Good Standing from the jurisdiction's Secretary of State in which I am applying
 8. For Non-Resident License Applications, I certify that I am licensed and in good standing in my home state/resident state for the lines of authority requested from the non-resident state

Attachments

- 11 The following attachments must accompany the application otherwise the application may be returned unprocessed or considered deficient
1. For Non-Resident License Applications and unless otherwise noted in the State Matrix of Business Rules, a state will rely on an electronic verification of an applicant's resident license through the NAIC's Producer Database in lieu of requiring an original Letter of Certification from the resident state
 2. Any jurisdiction specific attachments listed in the State Matrix of Business Rules (www.licenseregistry.com).

Must be signed by an officer, director, principal or partner of the business entity:

September 9 2005
Month Day Year


Signature

Jed Brettschneider

Typed or Printed Name
President & CEO

Title


Social Security Number
7 Wells Avenue - Suite 24

Address
Newton, MA 02459
City State Zip

NEW ENGLAND CUSTOM HEALTH
PLAN ADMINISTRATORS, LLC
275 GROVE STREET
NEWTON, MA 02466



1193

PAY TO THE
ORDER OF
MA Division of Insurance

9/9/2005

\$ **150.00

One Hundred Fifty and 00/100*****
Commonwealth of Massachusetts
Division of Insurance
One South Station, 5th Floor
Boston, MA 02110-2208

DOLLARS

MEMO:

James Brennan

Security features. Details on back

Please note the application may be revised on an annual basis. To ensure you are filing the current version reference the National Insurance Producer Registry web site at www.licenseregistry.com.



**Uniform Application for
Business Entity Insurance License Registration**
(Please Print or Type)

DIVISION OF INSURANCE
PRODUCER LICENSE REGISTRATION
SEP 21 2006
PROCESSED

EXHIBIT
D
(6 pages)

Renewing Business Entity

1002

Check appropriate box for license requested.

- Resident License
- Non-Resident License
 - Identify Home State: _____
 - Identify Home State License #: _____

① Business Entity Name New England Custom Health Plan Administrators, LLC		② Incorporation/Formation Date June 1, 2004		③ FEIN 20 - 1308264	
④ If assigned, National Producer Number (NP#)			⑤ If applicable, NASD Firm Central Registration Depository (CRD) Number		
⑥ List any other assumed, fictitious, alias or trade names under which you are doing business or intend to do business ATA Direct			⑦ State of Domicile MA		⑧ Country of Domicile USA
⑨ Is the business entity affiliated with a financial institution/bank? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
⑩ Business Address 7 Wells Avenue - Suite 24		⑪ City Newton	⑫ State MA	⑬ Zip Code 02459	⑭ Foreign Country
⑮ Phone Number (617) 581 - 6655	⑯ Fax Number (617) 249 - 0217	⑰ Business Web Site Address www.atadirect.com		⑱ Business E-Mail Address info@atadirect.com	
⑲ Mailing Address 7 Wells Avenue - Suite 24		⑳ P.O. Box	㉑ City Newton	㉒ State MA	㉓ Zip Code 024569
Designated/Responsible Licensed Producer					
㉔ Identify at least one Designated/Responsible Licensed Producer (See Matrix of State Requirements at www.licenseregistry.com for jurisdictions that require the designated/responsible licensed producer to be an officer, director or partner of the business entity.)					
Name Michael Cassandro	SSN	[REDACTED]			
Name _____	SSN	- - -			
Name _____	SSN	- - -			
Name _____	SSN	- - -			
Owners, Partners, Officers and Directors					
㉕ Identify all owners with 10% interest or voting interest, partners, officers and directors of the business entity:					
Name Jed Brettschneider	Title President & CEO	SSN/FEIN	[REDACTED]		Owner: Yes/No
Name Michael Cassandro	Title Regional Director	SSN/FEIN	[REDACTED]		Owner: Yes/No
Name _____	Title _____	SSN/FEIN	- - -		Owner: Yes / No
Name _____	Title _____	SSN/FEIN	- - -		Owner: Yes / No
Name _____	Title _____	SSN/FEIN	- - -		Owner: Yes / No
Name _____	Title _____	SSN/FEIN	- - -		Owner: Yes / No
Name _____	Title _____	SSN/FEIN	- - -		Owner: Yes / No
Name _____	Title _____	SSN/FEIN	- - -		Owner: Yes / No

(State Use)

Please note the application may be revised on an annual basis. To ensure you are filing the current version of the application, please reference the National Insurance Producer Registry website at www.nipr.com or www.licenseregistry.com.

Jurisdiction and Type of License Registration Requested - Major Lines of Authority

(27) Next to each jurisdiction, check the legal business type, license registration type(s) and line(s) of authority for which you are applying.

Legal Business Type: C - Corporation P - Partnership S - Sole Proprietorship LLC - Limited Liability Company LLP - Limited Liability Partnership
 License/Registration Types: A - Agent B - Broker P - Producer SLP - Surplus Lines Producer Y - Business Entity
 Lines of Authority: V - Variable Life/Variable Annuity L - Life H - Health or Accidental Death and Sickness P - Property C - Casualty PL - Personal Lines

Jurisdiction	Legal Business Type					Registration Type				Lines of Authority					
	C	P	S	LLC	LLP	V	P	SLP	Y	V	L	H	P	C	PL
AK															
AL															
AR															
AZ															
CA															
CO															
CT															
DC															
DE															
FL															
GA															
GU															
HI															
IA															
ID															
IL															
IN															
KS															
KY															
LA															
✓ MA															
MD															
ME															
MI															
MN															
MO															
MS															
MT															
NC															
ND															
NE															
NH															
NJ															
NM															
NV															
NY															
OH															
OK															
OR															
PA															
PR															
RI															
SC															
SD															
TN															
TX															
UT															
VA															
VI															
VT															
WA															
WI															
WV															
WY															

Jurisdiction and Type of License/Registration - Limited Lines of Authority

(28) Next to each jurisdiction, check the legal business type, license/registration type(s) and line(s) of authority for which you are applying.

Legal Business Type: C - Corporation P - Partnership S - Sole Proprietorship LLC - Limited Liability Company LLP - Limited Liability Partnership
 License/Registration Types: A - Agent B - Broker I - Insurer SLP - Surplus Lines Producer Y - Business Entity
 Limited Lines: Credit - Credit CR - Car Rental Crop - Crop T - Travel S - Surety O - Other Specify Type

Jurisdiction	Legal Business Type					License/Registration Type				Lines of Authority						
	C	P	S	LLC	LLP	A	B	I	SLP	Y	Credit	CR	Crop	T	S	O
AK																
AL																
AR																
AZ																
CA																
CO																
CT																
DC																
DE																
FL																
GA																
GU																
HI																
IA																
ID																
IL																
IN																
KS																
KY																
LA																
MA																
MD																
ME																
MI																
MN																
MO																
MS																
MT																
NC																
ND																
NE																
NH																
NJ																
NM																
NV																
NY																
OH																
OK																
OR																
PA																
PR																
RI																
SC																
SD																
TN																
TX																
UT																
VA																
VI																
VT																
WA																
WI																
WV																
WY																

Background Information

29) Please read the following very carefully and answer every question. All copies of documents must be certified. All written statements submitted by the Applicant must include an original signature.

1. Has the business entity or any owner, partner, officer or director ever been convicted of, or is the business entity or any owner, partner, officer or director currently charged with, committing a crime, whether or not adjudication was withheld? Yes ___ No X

"Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

If you answer yes, you must attach to this application:

- a written statement explaining the circumstances of each incident,
- a certified copy of the charging document, and
- a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

2. Has the business entity or any owner, partner, officer or director ever been involved in an administrative proceeding regarding any professional or occupational license? Yes ___ No X

"Involved" means having a license censured, suspended, revoked, canceled, terminated, or, being assessed a fine, a cease and desist order, a prohibition order, a compliance order, placed on probation or surrendering a license to resolve an administrative action. "Involved" also means being named as a party to an administrative or arbitration proceeding, which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may EXCLUDE terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

- a written statement identifying the type of license and explaining the circumstances of each incident,
- a certified copy of the Notice of Hearing or other document that states the charges and allegations, and
- a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has any demand been made or judgment rendered against the business entity or any owner, partner, officer or director for overdue monies by an insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding? Yes ___ No X

If you answer yes, submit a statement summarizing the details of the indebtedness and arrangements for repayment.

4. Has the business entity or any owner, partner, officer or director ever been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement? Yes ___ No X

If you answer yes, identify the jurisdiction(s): _____

5. Is the business entity or any owner, partner, officer or director a party to, or ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty? Yes ___ No X

If you answer yes, you must attach to this application:

- a written statement summarizing the details of each incident,
- a certified copy of the Petition, Complaint or other document that commenced the lawsuit or arbitration, and
- a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

6. Has the business entity or any owner, partner, officer or director ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes ___ No X

If you answer yes, you must attach to this application:

- a written statement summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
- certified copies of all relevant documents.

Applicants Certification and Attestation

30 The undersigned owner, partner, officer or director of the business entity hereby certifies, under penalty of perjury, that:

- 1 All of the information submitted in this application and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me and the business entity to civil or criminal penalties
- 2 Where required by law, the business entity hereby designates the Commissioner, Director or Superintendent of Insurance, or an appropriate representative in each jurisdiction for which this application is made to be its agent for service of process regarding all insurance matters in the respective jurisdiction and agree that service upon the Commissioner or Director of that jurisdiction is of the same legal force and validity as personal service upon the business entity
- 3 The business entity grants permission to the Commissioner or Director of Insurance in each jurisdiction for which this application is made to verify any information supplied with any federal, state or local government agency, current or former employer or insurance company
- 4 Every owner, partner, officer or director of the business entity either a) does not have a current child-support obligation, or b) has a child-support obligation and is currently in compliance with that obligation
- 5 I authorize the jurisdictions to give any information they may have concerning me to any federal, state or municipal agency, or any other organization and I release the jurisdictions and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information
- 6 I acknowledge that I understand and comply with the insurance laws and regulations of the jurisdictions to which I am applying for licensure/registration
- 7 If required, I have received a Certificate of Good Standing from the jurisdiction's Secretary of State in which I am applying
- 8 For Non-Resident License Applications, I certify that I am licensed and in good standing in my home state/resident state for the lines of authority requested from the non-resident state

Attachments

31 The following attachments must accompany the application otherwise the application may be returned unprocessed or considered deficient

- 1 For Non-Resident License Applications and unless otherwise noted in the State Matrix of Business Rules, a state will rely on an electronic verification of an applicant's resident license through the NAIC's Producer Database in lieu of requiring an original Letter of Certification from the resident state.
- 2 Any jurisdiction specific attachments listed in the State Matrix of Business Rules (www.licenseregistry.com).

Must be signed by an officer, director, principal or partner of the business entity:

September 08, 2006

Month Day Year


Signature

Jed Brettschneider Jed Brettschneider
Typed or Printed Name

President & CEO
Title


Social Security Number
7 Wells Avenue - Suite 24

Address

Newton MA 02459
City State Zip

Bank of America



MIDDLESEX SAVINGS BANK 52 1002
 NEEDHAM, MA 02452
 9/7/2006
 SA 1122/2113

N.E. CUSTOM HEALTH PLAN ADMINISTRATORS
 7 WELLS AVE STE 24
 NEWTON, MA 02459

PAY TO THE ORDER OF Commonwealth of MA \$ **150.00

One Hundred Fifty and 00/100*..... DOLLARS

Div. of Insurance - Producer Licensing
 P.O. Box 370043
 Boston, MA 02241-1743

MEMO Renew Business entity license

[Signature]

Batch:
8317609

LOCKBOX	BATCH	ITEM	IMAGE	DATE	AMOUNT
370043	2	27	27	September 11, 2006	\$ 150.00
BOSTON	SITE				

Commonwealth of MA

9/7/2006

1002

150.00

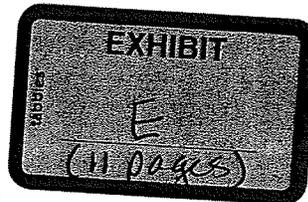
Middlesex Checking

Renew Business entity license

150.00



**Uniform Application for
Business Entity Insurance License/Registration**
(Please Print or Type)



New

Check appropriate box for license requested.

- Resident License
- Non-Resident License
 - Identify Home State: _____
 - Identify Home State License #: _____

Demographic Information

① Business Entity Name HMA MGU, LLC.		② Incorporation/Formation Date (month) <u>10</u> (day) <u>02</u> (year) <u>2006</u>		③ FEIN 20 - 5820758	
④ If assigned, National Producer Number (NP#)			⑤ If applicable, NASD Firm Central Registration Depository (CRD) Number		
⑥ List any other assumed, fictitious, alias or trade names under which you are doing business or intend to do business			⑦ State of Domicile MA		⑧ Country of Domicile USA
⑨ Is the business entity affiliated with a financial institution/bank? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
⑩ Business Address 7 Wells Avenue, Suite 24		⑪ City Newton	⑫ State MA	⑬ Zip Code 02459	⑭ Foreign Country N/A
⑮ Phone Number (include extension) (617) 581 - 6655	⑯ Fax Number (617) 249 -0217	⑰ Business Web Site Address www.hmadirect.com		⑱ Business E-Mail Address jbrett@hmadirect.com	
⑲ Mailing Address 7 Wells Avenue, Suite 24		⑳ P.O. Box	㉑ City Newton	㉒ State MA	㉓ Zip Code 02459
㉔ Foreign Country N/A					

Designated/Responsible Licensed Producer

㉕ Identify at least one Designated/Responsible Licensed Producer: (See Matrix of State Requirements at www.licenseregistry.com for jurisdictions that require the designated/responsible licensed producer to be an officer, director or partner of the business entity.)

Name Jedediah L. Brettschneider SSN [REDACTED]

Name _____ SSN _____

Name _____ SSN _____

Name _____ SSN _____

DIVISION OF INSURANCE
PRODUCER LICENSING

MAY 21 2007

PROCESSED

Owners, Partners, Officers and Directors

㉖ Identify all owners with 10% interest or voting interest, partners, officers and directors of the business entity, or members or managers of a limited liability company:

Name <u>Health Management Advisors, LLC.</u>	Title <u>Owner</u>	SSN/FEIN <u>[REDACTED]</u>	Owner: <u>Yes / No</u>
Name <u>Jedediah L. Brettschneider</u>	Title <u>Managing Member</u>	SSN/FEIN <u>[REDACTED]</u>	Owner: <u>Yes / No</u>
Name _____	Title _____	SSN/FEIN _____	Owner: <u>Yes / No</u>
Name _____	Title _____	SSN/FEIN _____	Owner: <u>Yes / No</u>
Name _____	Title _____	SSN/FEIN _____	Owner: <u>Yes / No</u>
Name _____	Title _____	SSN/FEIN _____	Owner: <u>Yes / No</u>
Name _____	Title _____	SSN/FEIN _____	Owner: <u>Yes / No</u>
Name _____	Title _____	SSN/FEIN _____	Owner: <u>Yes / No</u>

(State Use)



Uniform Application for Business Entity Insurance License/Registration

(Please Print or Type)

Check appropriate box for license requested.

- Resident License
- Non-Resident License
 - Identify Home State: _____
 - Identify Home State License #: _____

Demographic Information

1 Business Entity Name HMA MGU, LLC.		2 Incorporation/Formation Date (month) <u>10</u> (day) <u>02</u> (year) <u>2006</u>		3 FEIN 20 - 5870758	
4 If assigned, National Producer Number (NP#)			5 If applicable, NASD Firm Central Registration Depository (CRD) Number		
6 List any other assumed, fictitious, alias or trade names under which you are doing business or intend to do business				7 State of Domicile MA	
				8 Country of Domicile USA	
9 Is the business entity affiliated with a financial institution/bank? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
10 Business Address 7 Wells Avenue, Suite 24		11 City Newton		12 State MA	13 Zip Code 02459
				14 Foreign Country N/A	
15 Phone Number (include extension) (617) 581 - 6655		16 Fax Number (617) 249 -0217	17 Business Web Site Address www.hmadirect.com		18 Business E-Mail Address jbrett@hmadirect.com
19 Mailing Address 7 Wells Avenue, Suite 24		20 P.O. Box	21 City Newton		22 State MA
					23 Zip Code 02459
					24 Foreign Country N/A

Designated/Responsible Licensed Producer

25 Identify at least one Designated/Responsible Licensed Producer: (See Matrix of State Requirements at www.licenseregistry.com for jurisdictions that require the designated/responsible licensed producer to be an officer, director or partner of the business entity.)

Name Jedediah L. Brettschneider SSN [REDACTED]

Name _____ SSN - -

Name _____ SSN - -

Name _____ SSN - -

Owners, Partners, Officers and Directors

26 Identify all owners with 10% interest or voting interest, partners, officers and directors of the business entity, or members or managers of a limited liability company:

Name <u>Health Management Advisors, LLC</u>	Title <u>Owner</u>	SSN/FEIN <u>[REDACTED]</u>	Owner: <u>Yes</u> / No
Name <u>Jedediah L. Brettschneider</u>	Title <u>Managing Member</u>	SSN/FEIN <u>[REDACTED]</u>	Owner: Yes / <u>No</u>
Name _____	Title _____	SSN/FEIN - -	Owner: Yes / No
Name _____	Title _____	SSN/FEIN - -	Owner: Yes / No
Name _____	Title _____	SSN/FEIN - -	Owner: Yes / No
Name _____	Title _____	SSN/FEIN - -	Owner: Yes / No
Name _____	Title _____	SSN/FEIN - -	Owner: Yes / No
Name _____	Title _____	SSN/FEIN - -	Owner: Yes / No

(State Use)



Uniform Application for Business Entity Insurance License/Registration

Jurisdiction and Type of License/Registration Requested –Major Lines of Authority

(27) Next to each jurisdiction, check the legal business type, license/registration type(s) and line(s) of authority for which you are applying.

Legal Business Type: C – Corporation P – Partnership S – S Corporation LLC – Limited Liability Company LLP – Limited Liability Partnership

License/Registration Types: A – Agent B – Broker P – Producer SLP – Surplus Lines Producer Y – Business Entity

Lines of Authority: V – Variable Life/Variable Annuity L – Life H – Health & Health Care P – Property C – Casualty PL – Personal Lines

Jurisdiction	Legal Business Type					License/Registration Type					Lines of Authority					
	C	P	S	LLC	LLP	A	B	P	SLP	Y	V	L	H	P	C	PL
AK																
AL																
AR																
AZ																
CA																
CO																
CT																
DC																
DE																
FL																
GA																
GU																
HI																
IA																
ID																
IL																
IN																
KS																
KY																
LA																
MA				XX				XX				XX	XX			
MD																
ME																
MI																
MN																
MO																
MS																
MT																
NC																
ND																
NE																
NH																
NJ																
NM																
NV																
NY																
OH																
OK																
OR																
PA																
PR																
RJ																
SC																
SD																
TN																
TX																
UT																
VA																
VI																
VT																
WA																
WI																
WV																
WY																



Uniform Application for Business Entity Insurance License/Registration

Jurisdiction and Type of License/Registration - Limited Lines of Authority

28 Next to each jurisdiction, check the legal business type, license/registration type(s) and line(s) of authority for which you are applying.

Legal Business Type: C - Corporation P - Partnership S - Sole Proprietorship LLC - Limited Liability Company LLP - Limited Liability Partnership
 License/Registration Types: A - Agent B - Broker P - Producer SLP - Surplus Lines Producer Y - Business Entity
 Limited Lines: Credit - Credit CR - Car Rental Crop - Crop T - Travel S - Surety O - Other Specify Type

Jurisdiction	Legal Business Type					License/Registration Type					Lines of Authority					
	C	P	S	LLC	LLP	A	B	P	SLP	Y	Credit	CR	Crop	T	S	O
AK																
AL																
AR																
AZ																
CA																
CO																
CT																
DC																
DE																
FL																
GA																
GU																
HI																
IA																
ID																
IL																
IN																
KS																
KY																
LA																
MA				XX				XX								
MD																
ME																
MI																
MN																
MO																
MS																
MT																
NC																
ND																
NE																
NH																
NJ																
NM																
NV																
NY																
OH																
OK																
OR																
PA																
PR																
RI																
SC																
SD																
TN																
TX																
UT																
VA																
VI																
VT																
WA																
WI																
WV																
WY																



Uniform Application for Business Entity Insurance License/Registration

Background Information

29) Please read the following very carefully and answer every question. All copies of documents must be certified. All written statements submitted by the Applicant must include an original signature.

1. Has the business entity or any owner, partner, officer or director of the business entity, or member or manager of a limited liability company, ever been convicted of, or is the business entity or any owner, partner, officer or director, member or manager currently charged with, committing a crime, had a judgment withheld or deferred, or are you currently charged with committing a crime? Yes ___ No X

"Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations or convictions involving driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license and juvenile offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

If you answer yes, you must attach to this application:

- a) a written statement explaining the circumstances of each incident,
- b) a certified copy of the charging document,
- c) a certified copy of the official document, which demonstrates the resolution of the charges or any final judgment

2. Has the business entity or any owner, partner, officer or director, or manager or member of a limited liability company, ever been involved in an administrative proceeding regarding any professional or occupational license, or registration? Yes ___ No X

"Involved" means having a license censured, suspended, revoked, canceled, terminated; or, being assessed a fine, a cease and desist order, a prohibition order, a compliance order, placed on probation or surrendering a license to resolve an administrative action.

"Involved" also means being named as a party to an administrative or arbitration proceeding, which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may EXCLUDE terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

- a) a written statement identifying the type of license and explaining the circumstances of each incident,
- b) a certified copy of the Notice of Hearing or other document that states the charges and allegations, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has any demand been made or judgment rendered against the business entity or any owner, partner, officer or director, or member or manager if a limited liability company, for overdue monies by an insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding? Only include bankruptcies that involve funds held on behalf of others. Yes ___ No X

If you answer yes, submit a statement summarizing the details of the indebtedness and arrangements for repayment

4. Has the business entity or any owner, partner, officer or director, or member or manager of a limited liability company, ever been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement? Yes ___ No X

If you answer yes, identify the jurisdiction(s): _____

5. Is the business entity or any owner, partner, officer or director a party to, or ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty? Yes ___ No X

If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident,
- b) a certified copy of the Petition, Complaint or other document that commenced the lawsuit or arbitration, and
- c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

6. Has the business entity or any owner, partner, officer or director, or member or manager if a limited liability company, ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes ___ No X

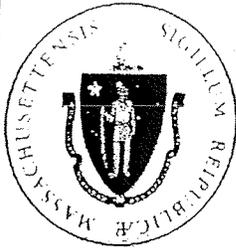
If you answer yes, you must attach to this application:

- a) a written statement summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
- b) certified copies of all relevant documents.

HMA MGU, LLC.

Member List

Jedediah L. Brettschneider Managing Member Licensed Resident Producing Agent MA Lic #1769859



The Commonwealth of Massachusetts
William Francis Galvin

Minimum Fee: \$500.00

Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512
Telephone: (617) 727-9640

Certificate of Organization
(General Laws, Chapter)

Federal Employer Identification Number: 000934330 (must be 9 digits)

1. The exact name of the limited liability company is: HMA MGU, LLC

2a. Location of its principal office is:

No. and Street: 7 WELLS AVENUE

STE 24

City or Town: NEWTON

State: MA

Zip: 02459

Country: USA

2b. Street address of the office in the Commonwealth at which the records will be maintained:

No. and Street: 7 WELLS AVENUE

STE 24

City or Town: NEWTON

State: MA

Zip: 02459

Country: USA

3. The general character of business, and if the limited liability company is organized to render professional service, the service to be rendered:

MANAGING UNDERWRITER

4. The latest date of dissolution, if specified:

5. Name and address of the Resident Agent is:

Name: JED BRETTSCHEIDER

No. and Street: 7 WELLS AVENUE

STE 24

City or Town: NEWTON

State: MA

Zip: 02459

Country: USA

6. The name and business address of each manager:

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
MANAGER	JED BRETTSCHEIDER	7 WELLS AVENUE NEWTON, MA 02459 USA

7. The name and business address of the person in addition to the manager, who is authorized to execute documents to be filed with the Corporations Division, and at least one person shall be named if there are no managers.

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code

Prior to August 27, 2001, Records can be obtained on Microfilm

8. The name and business address of the person(s) authorized to execute, acknowledge, deliver and record any recordable Instrument purporting to affect an interest in real property:

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
Prior to August 27, 2001, Records can be obtained on Microfilm		

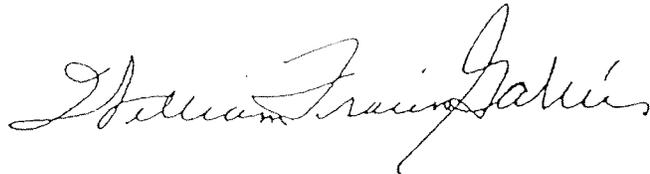
9. Any additional matters the authorized persons determine to include therein:

SIGNED UNDER THE PENALTIES OF PERJURY, this 29 Day of September, 2006,
JOSEPH J COLLOPY
(The certificate must be signed by the person forming the LLC.)

THE COMMONWEALTH OF MASSACHUSETTS

I hereby certify that, upon examination of this document, duly submitted to me, it appears that the provisions of the General Laws relative to corporations have been complied with, and I hereby approve said articles; and the filing fee having been paid, said articles are

deemed to have been filed with me on:

A handwritten signature in cursive script, reading "William Francis Galvin". The signature is written in dark ink and is centered on the page.

WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

N.E. CUSTOM HEALTH PLAN ADMINISTRATORS
7 Wells Ave. Suite 24
Newton, MA 02459

Mellon Financial
1 Boston Place
Boston, MA 02108

1804

1-023116

5/13/2008

PAY
TO THE
ORDER OF

Commonwealth of Massachusetts

\$ 75.00

Seventy-Five and 00/100 ***** DOLLARS

Division of Insurance
Attn: Producer Licensing
P O Box 370043
Boston, MA 02241-1743



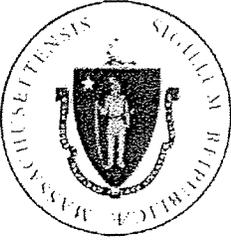
MEMO

Business Entity Insurance License

[REDACTED]

Batch 8317151

LOCKBOX	BATCH	ITEM	IMAGE	DATE	AMOUNT
370043	4	17	17	May 15, 2008	\$ 75.00
BOSTON	SITE				



The Commonwealth of Massachusetts
William Francis Galvin

Secretary of the Commonwealth, Corporations Division
One Ashburton Place, 17th floor
Boston, MA 02108-1512
Telephone: (617) 727-9640



HEALTH MANAGEMENT ADVISORS, LLC Summary Screen



Help with this form

Request a Certificate

The exact name of the Domestic Limited Liability Company (LLC): HEALTH MANAGEMENT ADVISORS, LLC

Entity Type: Domestic Limited Liability Company (LLC)

Identification Number: 205870176

Old Federal Employer Identification Number (Old FEIN): 000934328

Date of Organization in Massachusetts: 09/29/2006

The location of its principal office:

No. and Street: 7 WELLS AVE.,
City or Town: NEWTON State: MA Zip: 02459 Country: USA

If the business entity is organized wholly to do business outside Massachusetts, the location of that office:

No. and Street:
City or Town: State: Zip: Country:

The name and address of the Resident Agent:

Name: JEDEDIAH BRETTSCHEIDER
No. and Street: 3 TALBOT DR.
City or Town: NORTON State: MA Zip: 02766 Country: USA

The name and business address of each manager:

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
MANAGER	JEDEDIAH BRETTSCHEIDER	3 TALBOT DR. NORTON, MA 02766 USA

The name and business address of the person in addition to the manager, who is authorized to execute documents to be filed with the Corporations Division.

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
SOC SIGNATORY	JEDEDIAH BRETTSCHEIDER	3 TALBOT DR. NORTON, MA 02766 USA

The name and business address of the person(s) authorized to execute, acknowledge, deliver and record any recordable instrument purporting to affect an interest in real property

Title	Individual Name <small>First, Middle, Last, Suffix</small>	Address <small>(no PO Box)</small> <small>Address, City or Town, State, Zip Code</small>
REAL PROPERTY	JEDEDIAH BRETTSCHEIDER	3 TALBOT DR. NORTON, MA 02766 USA

Consent Manufacturer Confidential Data Does Not Require Annual Report
 Partnership Resident Agent For Profit Merger Allowed

Select a type of filing from below to view this business entity filings:

ALL FILINGS
 Annual Report
 Articles of Entity Conversion
 Certificate of Amendment
 Certificate of Cancellation

[View Filings](#)

[New Search](#)

Comments

© 2001 - 2009 Commonwealth of Massachusetts
All Rights Reserved

 Help

FILED

9/29/2006

~~2008~~ 2008

**ANNUAL REPORT
HEALTH MANAGEMENT ADVISORS, LLC
2008**

SECRETARY OF THE COMMONWEALTH
CORPORATIONS DIVISION

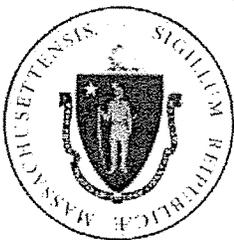
Pursuant to the provisions of General Laws Chapter 156C, Section 19 of the Massachusetts Limited Liability Company Act (the "Act"), the undersigned hereby certifies as follows:

1. Name of Limited Liability Company. The name of the limited liability company (the "LLC") is Health Management Advisors, LLC.
2. Office of the Limited Liability Company. The address of the office of the LLC for purposes of Section 5 of the Act is 7 Wells Avenue, Newton, MA 02459.
3. Agent for Service of Process. The name and address of the resident agent for service of process for the LLC is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766
4. Latest Dissolution Date. The LLC is to have no specific date of dissolution.
5. Manager. The name and address of the manager of the LLC for purposes of the Act is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.
6. Persons Authorized to Execute Documents for Filing with Secretary of State. The name and address of the person authorized to execute any documents to be filed with the Secretary of State of the Commonwealth of Massachusetts is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.
7. Persons Authorized to Execute and Record Real Estate Instruments. The name and address of the person authorized to execute, acknowledge, deliver, and record real estate documents is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.
8. Business of LLC. The general character of the business of the LLC is to:
 - a. Engage in the marketing, sale, and administration of various healthcare insurance products; and
 - b. Conduct such other business activities and operations that are consistent with and reasonably related to the forgoing, including any lawful purpose permitted under the provisions of MGL Chapter 156C, as amended, whether or not the same are in furtherance of the foregoing specific purposes.
9. Federal Identification No. 20-5870176.

IN WITNESS WHEREOF, the undersigned hereby affirms under the penalties of perjury that the facts stated herein are true, this 8th day of APRIL '08.

By: 

2008006806



**The Commonwealth of Massachusetts
William Francis Galvin**

Secretary of the Commonwealth, Corporations Division
One Ashburton Place, 17th floor
Boston, MA 02108-1512
Telephone: (617) 727-9640



HMA ADMINISTRATORS, LLC Summary Screen



Help with this form

[Request a Certificate](#)

The exact name of the Domestic Limited Liability Company (LLC): HMA ADMINISTRATORS, LLC

Entity Type: Domestic Limited Liability Company (LLC)

Identification Number: 000934329

Date of Organization in Massachusetts: 09/29/2006

The location of its principal office:

No. and Street: 7 WELLS AVENUE
STE 24
City or Town: NEWTON State: MA Zip: 02459 Country: USA

If the business entity is organized wholly to do business outside Massachusetts, the location of that office:

No. and Street:
City or Town: State: Zip: Country:

The name and address of the Resident Agent:

Name: JEDEDIAH BRETTSCHEIDER
No. and Street: 3 TALBOT DR
City or Town: NORTON State: MA Zip: 02766 Country: USA

The name and business address of each manager:

Title	Individual Name <small>First, Middle, Last, Suffix</small>	Address (no PO Box) <small>Address, City or Town, State, Zip Code</small>
MANAGER	JEAN BUEHLER	7 WELLS AVENUE NEWTON, MA 02459 USA

The name and business address of the person in addition to the manager, who is authorized to execute documents to be filed with the Corporations Division.

Title	Individual Name <small>First, Middle, Last, Suffix</small>	Address (no PO Box) <small>Address, City or Town, State, Zip Code</small>
SOC SIGNATORY	JEAN BUEHLER	7 WELLS AVENUE NEWTON, MA 02459 USA

The name and business address of the person(s) authorized to execute, acknowledge, deliver and record any recordable instrument purporting to affect an interest in real property

Title	Individual Name <small>First, Middle, Last, Suffix</small>	Address (no PO Box) <small>Address, City or Town, State, Zip Code</small>
-------	---	--

REAL PROPERTY

JEAN BUEHLER

7 WELLS AVENUE
NEWTON, MA 02459 USA

Consent Manufacturer Confidential Data Does Not Require Annual Report
 Partnership Resident Agent For Profit Merger Allowed

Select a type of filing from below to view this business entity filings:

ALL FILINGS
Annual Report
Articles of Entity Conversion
Certificate of Amendment
Certificate of Cancellation

[View Filings](#)

[New Search](#)

Comments

© 2001 - 2009 Commonwealth of Massachusetts
All Rights Reserved

[?](#)
Help

9/29/2006

ANNUAL REPORT
HMA ADMINISTRATORS, LLC
2008

\$500 FEE

FILED

APR 09 2008

SECRETARY OF STATE
CORPORATION DIVISION
HEALTH

Pursuant to the provisions of General Laws Chapter 156C, Section 19 of the Massachusetts Limited Liability Company Act (the "Act"), the undersigned hereby certifies as follows:

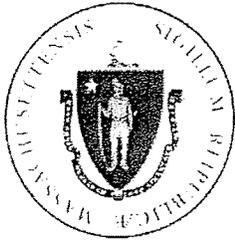
1. Name of Limited Liability Company. The name of the limited liability company (the "LLC") is HMA Administrators, LLC.
2. Office of the Limited Liability Company. The address of the office of the LLC for purposes of Section 5 of the Act is 7 Wells Avenue, Newton, MA 02459.
3. Agent for Service of Process. The name and address of the resident agent for service of process for the LLC is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766
4. Latest Dissolution Date. The LLC is to have no specific date of dissolution.
5. Manager. The name and address of the manager of the LLC for purposes of the Act is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.
6. Persons Authorized to Execute Documents for Filing with Secretary of State. The name and address of the person authorized to execute any documents to be filed with the Secretary of State of the Commonwealth of Massachusetts is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.
7. Persons Authorized to Execute and Record Real Estate Instruments. The name and address of the person authorized to execute, acknowledge, deliver, and record real estate documents is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.
8. Business of LLC. The general character of the business of the LLC is to:
 - a. Engage in the administration of various healthcare insurance products; and
 - b. Conduct such other business activities and operations that are consistent with and reasonably related to the forgoing, including any lawful purpose permitted under the provisions of MGL Chapter 156C, as amended, whether or not the same are in furtherance of the foregoing specific purposes.
9. Federal Identification No. 30-0390442.

IN WITNESS WHEREOF, the undersigned hereby affirms under the penalties of perjury that the facts stated herein are true, this 8TH day of APRIL '08.

By: _____

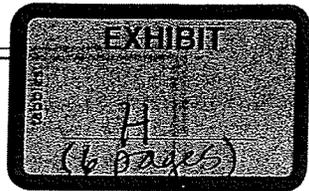


2008006807



**The Commonwealth of Massachusetts
William Francis Galvin**

Secretary of the Commonwealth, Corporations Division
One Ashburton Place, 17th floor
Boston, MA 02108-1512
Telephone: (617) 727-9640



HMA MGU, LLC Summary Screen

[?](#)
Help with this form

[Request a Certificate](#)

The exact name of the Domestic Limited Liability Company (LLC): HMA MGU, LLC

Entity Type: Domestic Limited Liability Company (LLC)

Identification Number: 205870758

Old Federal Employer Identification Number (Old FEIN): 000934330

Date of Organization in Massachusetts: 09/29/2006

The location of its principal office:

No. and Street: 7 WELLS AVENUE
STE 27
City or Town: NEWTON State: MA Zip: 02459 Country: USA

If the business entity is organized wholly to do business outside Massachusetts, the location of that office:

No. and Street:
City or Town: State: Zip: Country:

The name and address of the Resident Agent:

Name: SHELLEY LENKUTIS
No. and Street: 7 WELLS AVENUE, #27
City or Town: NEWTON State: MA Zip: 02459 Country: USA

The name and business address of each manager:

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
MANAGER	SHELLEY LENKUTIS	7 WELLS AVE., #27 NEWTON, MA 02459 USA

The name and business address of the person in addition to the manager, who is authorized to execute documents to be filed with the Corporations Division.

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
SOC SIGNATORY	SHELLEY LENKUTIS	7 WELLS AVE., #27 NEWTON, MA 02459 USA

The name and business address of the person(s) authorized to execute, acknowledge, deliver and record any

recordable instrument purporting to affect an interest in real property

Title	Individual Name <small>First, Middle, Last, Suffix</small>	Address <small>(no PO Box)</small> <small>Address, City or Town, State, Zip Code</small>
REAL PROPERTY	SHELLEY LENKUTIS	7 WELLS AVE , #27 NEWTON, MA 02459 USA

Consent
 Manufacturer
 Confidential Data
 Does Not Require Annual Report
 Partnership
 Resident Agent
 For Profit
 Merger Allowed

Select a type of filing from below to view this business entity filings:

- ALL FILINGS
- Annual Report
- Articles of Entity Conversion
- Certificate of Amendment
- Certificate of Cancellation

Comments

9/29/2006

ANNUAL REPORT
HMA MGU, LLC
2008

\$500 FEE **FILED**

APR 09 2008

SECRETARY OF THE COMMONWEALTH
CORPORATIONS DIVISION

Pursuant to the provisions of General Laws Chapter 156C, Section 19 of the Massachusetts Limited Liability Company Act (the "Act"), the undersigned hereby certifies as follows:

1. Name of Limited Liability Company. The name of the limited liability company (the "LLC") is HMA MGU, LLC.

2. Office of the Limited Liability Company. The address of the office of the LLC for purposes of Section 5 of the Act is 7 Wells Avenue, Newton, MA 02459.

3. Agent for Service of Process. The name and address of the resident agent for service of process for the LLC is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766

4. Latest Dissolution Date. The LLC is to have no specific date of dissolution.

5. Manager. The name and address of the manager of the LLC for purposes of the Act is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.

6. Persons Authorized to Execute Documents for Filing with Secretary of State. The name and address of the person authorized to execute any documents to be filed with the Secretary of State of the Commonwealth of Massachusetts is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.

7. Persons Authorized to Execute and Record Real Estate Instruments. The name and address of the person authorized to execute, acknowledge, deliver, and record real estate documents is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.

8. Business of LLC. The general character of the business of the LLC is to:

- a. Engage in the underwriting and administration of various healthcare insurance products; and
- b. Conduct such other business activities and operations that are consistent with and reasonably related to the foregoing, including any lawful purpose permitted under the provisions of MGL Chapter 156C, as amended, whether or not the same are in furtherance of the foregoing specific purposes.

9. Federal Identification No. 20-5820758.

IN WITNESS WHEREOF, the undersigned hereby affirms under the penalties of perjury that the facts stated herein are true, this 8th day of APRIL '08.

By:  _____

2008006808



The Commonwealth of Massachusetts
William Francis Galvin

Minimum Fee: \$500.00

Secretary of the Commonwealth
 One Ashburton Place, Boston, Massachusetts 02108-1512
 Telephone: (617) 727-9640

Certificate of Organization

(General Laws, Chapter)

Federal Employer Identification Number: 000934330 (must be 9 digits)

1. The exact name of the limited liability company is: HMA MGU, LLC

2a. Location of its principal office is:

No. and Street: 7 WELLS AVENUE

STE 24

City or Town: NEWTON

State: MA

Zip: 02459

Country: USA

2b. Street address of the office in the Commonwealth at which the records will be maintained:

No. and Street: 7 WELLS AVENUE

STE 24

City or Town: NEWTON

State: MA

Zip: 02459

Country: USA

3. The general character of business, and if the limited liability company is organized to render professional service, the service to be rendered:

MANAGING UNDERWRITER

4. The latest date of dissolution, if specified:

5. Name and address of the Resident Agent is:

Name: JED BRETTSCHEIDER

No. and Street: 7 WELLS AVENUE

STE 24

City or Town: NEWTON

State: MA

Zip: 02459

Country: USA

6. The name and business address of each manager:

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
MANAGER	JED BRETTSCHEIDER	7 WELLS AVENUE NEWTON, MA 02459 USA

7. The name and business address of the person in addition to the manager, who is authorized to execute documents to be filed with the Corporations Division, and at least one person shall be named if there are no managers.

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code

Prior to August 27, 2001, Records can be obtained on Microfilm

8. The name and business address of the person(s) authorized to execute, acknowledge, deliver and record any recordable instrument purporting to affect an interest in real property:

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
Prior to August 27, 2001, Records can be obtained on Microfilm		

9. Any additional matters the authorized persons determine to include therein:

SIGNED UNDER THE PENALTIES OF PERJURY, this 29 Day of September, 2006,
JOSEPH J COLLOPY
(The certificate must be signed by the person forming the LLC.)

THE COMMONWEALTH OF MASSACHUSETTS

I hereby certify that, upon examination of this document, duly submitted to me, it appears that the provisions of the General Laws relative to corporations have been complied with, and I hereby approve said articles; and the filing fee having been paid, said articles are

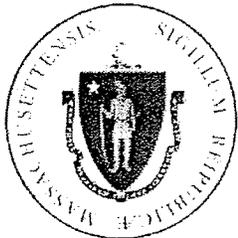
deemed to have been filed with me on:

September 29, 2006 11:44 AM

A handwritten signature in cursive script that reads "William Francis Galvin". The signature is written in black ink and is centered on the page.

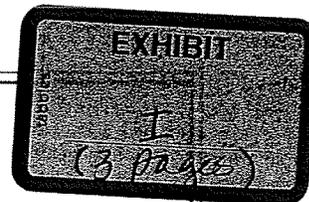
WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth



The Commonwealth of Massachusetts
William Francis Galvin

Secretary of the Commonwealth, Corporations Division
One Ashburton Place, 17th floor
Boston, MA 02108-1512
Telephone: (617) 727-9640



NEW ENGLAND CUSTOM HEALTH PLAN ADMINISTRATORS LLC Summary
Screen



Help with this form

Request a Certificate

The exact name of the Domestic Limited Liability Company (LLC): NEW ENGLAND CUSTOM HEALTH PLAN ADMINISTRATORS LLC

Entity Type: Domestic Limited Liability Company (LLC)

Identification Number: 201308264

Old Federal Employer Identification Number (Old FEIN): 000871516

Date of Organization in Massachusetts: 06/30/2004

The location of its principal office:

No. and Street: 7 WELLS AVE.
SUITE 24
City or Town: NEWTON State: MA Zip: 02459 Country: USA

If the business entity is organized wholly to do business outside Massachusetts, the location of that office:

No. and Street:
City or Town: State: Zip: Country:

The name and address of the Resident Agent:

Name: THE FREEMAN FIRM
No. and Street: 7 WELLS AVENUE, SUITE 23
City or Town: NEWTON State: MA Zip: 02459 Country: USA

The name and business address of each manager:

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
MANAGER	VICTOR M. LUGO	7 WELLS AVE. SUITE 24 NEWTON, MA 02459 USA

The name and business address of the person in addition to the manager, who is authorized to execute documents to be filed with the Corporations Division.

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
SOC SIGNATORY	VICTOR M. LUGO	7 WELLS AVE., SUITE 24 NEWTON, MA 02459 USA

The name and business address of the person(s) authorized to execute, acknowledge, deliver and record any recordable instrument purporting to affect an interest in real property

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code
REAL PROPERTY	VICTOR M. LUGO	7 WELLS AVE SUITE 24 NEWTON, MA 02459 USA

Consent
 Manufacturer
 Confidential Data
 Does Not Require Annual Report
 Partnership
 Resident Agent
 For Profit
 Merger Allowed

Select a type of filing from below to view this business entity filings:

ALL FILINGS
Annual Report
Articles of Entity Conversion
Certificate of Amendment
Certificate of Cancellation

Comments

6/30/2004

FILED
\$500 FEE

APR 09 2008

ANNUAL REPORT
NEW ENGLAND CUSTOM HEALTH PLAN ADMINISTRATORS, LLC
2008

SECRETARY OF THE COMMONWEALTH
CORPORATIONS DIVISION

Pursuant to the provisions of General Laws Chapter 156C, Section 19 of the Massachusetts Limited Liability Company Act (the "Act"), the undersigned hereby certifies as follows:

1. Name of Limited Liability Company. The name of the limited liability company (the "LLC") is New England Custom Health Plan Administrators, LLC.

2. Office of the Limited Liability Company. The address of the office of the LLC for purposes of Section 5 of the Act is 7 Wells Avenue, Newton, MA 02459.

3. Agent for Service of Process. The name and address of the resident agent for service of process for the LLC is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766

4. Latest Dissolution Date. The LLC is to have no specific date of dissolution.

5. Manager. The name and address of the manager of the LLC for purposes of the Act is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.

6. Persons Authorized to Execute Documents for Filing with Secretary of State. The name and address of the person authorized to execute any documents to be filed with the Secretary of State of the Commonwealth of Massachusetts is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.

7. Persons Authorized to Execute and Record Real Estate Instruments. The name and address of the person authorized to execute, acknowledge, deliver, and record real estate documents is Jedediah Brettschneider, 3 Talbot Drive, Norton, MA 02766.

8. Business of LLC. The general character of the business of the LLC is to:

- a. Engage in the sale and marketing of various healthcare insurance products; and
- b. Conduct such other business activities and operations that are consistent with and reasonably related to the forgoing, including any lawful purpose permitted under the provisions of MGL Chapter 156C, as amended, whether or not the same are in furtherance of the foregoing specific purposes.

9. Federal Identification No. 20-1308264.

IN WITNESS WHEREOF, the undersigned hereby affirms under the penalties of perjury that the facts stated herein are true, this 8TH day of APRIL '08.

By: AB1

2008006809

(Content)



Toll Free 888-333-8828

Contact Us | Sign up for our newsletter

- Home
- Who We Are ▶
- What We Do ▶
- How We Do It ▶
- Our Vision
- Contact Us ▶
- Employer Tools ▶
- Career Opportunities
- Company News
- Legal Information
- Privacy

About HMA Direct

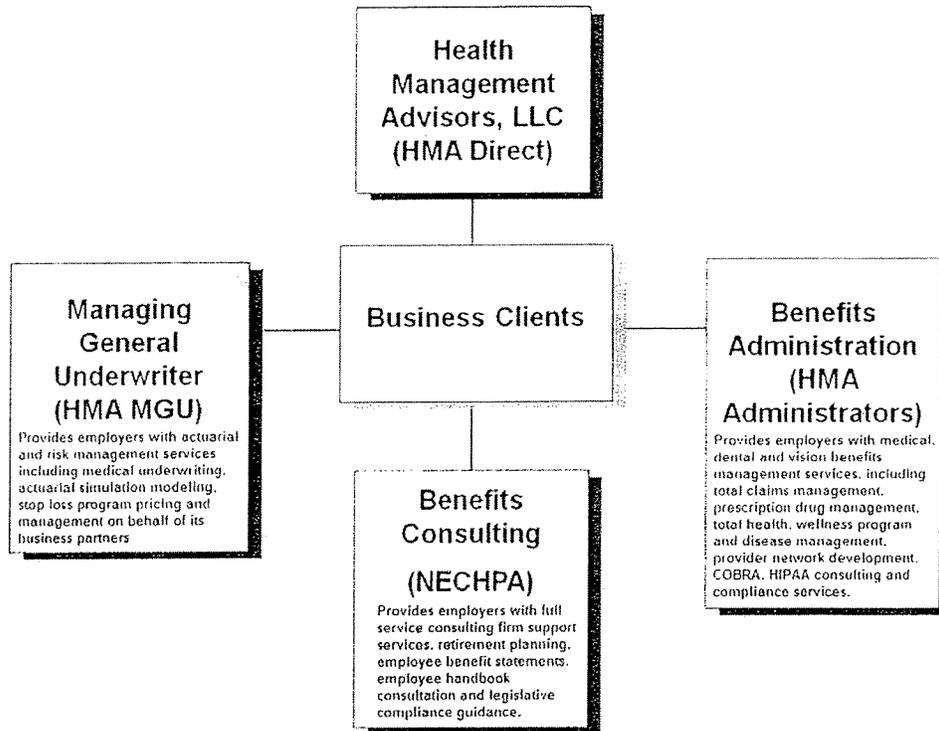
Health Management Advisors, LLC (HMA) dba HMA Direct is the parent company of a group of companies that trade together under the name HMA Direct. The subsidiary companies together constitute a full service actuarial and benefits consulting firm, a third party administrator, and a managing general underwriter.

The HMA Direct companies share a united mission of redefining the role, function, and value of benefit consulting in the US marketplace. This strategy seeks to constantly differentiate HMA Direct from other benefit consulting firms through the dedication of its skilled professionals, knowledge base, and the close working relationship between its clients and the firm. The Partially Self-Funded Health Plans are the fruits of this dedication and exemplify HMA Direct's ability to design quality and cost effective benefit solutions that meet the needs of clients across the country.

HMA Direct consists of three fully-integrated divisions.

Upcoming Events

- Metrics Seminar 5/28/09
- HR Basics Program 6/10/09
- Leading Change 6/17/09
- Neuro - Leadership 6/23/09



Headquartered in Newton, MA, with satellite centers strategically located around the U.S., the HMA Direct team is uniquely suited to meet the needs of clients. The core of HMA Direct's success is an unyielding focus on providing world class service to clients and their covered members.

In the news

Minimum Creditable Coverage (MCC)
Information about healthcare reform in Massachusetts.

2008 Special Olympics
HMA Direct is a proud sponsor of the 2008 special Olympics.

SAS 70 Compliance
HMA Direct is proud to announce that as of 12/31/07 we are a SAS70 compliant organization.

POMCO Group

Q&A with the CEO

Q: Is Partial Self-Funding or Fully Insured Best For Your Company?

Q: Is Partial Self-Funding Too Risky For Your Company?

Q: Is Partial Self-Funding Complicated To Set Up and Difficult To Administer?

Q: What is MCC? Why is the state doing this?

Q: What effect will MCC have on Massachusetts employers?

About HMA Direct

Health Management Advisors, LLC (HMA) dba HMA Direct is the parent company of a group of companies that trade together under the name HMA Direct. The subsidiary companies together constitute a full service actuarial and benefits consulting firm, a third party administrator, and a

HM Direct partners with HUMCO Group

HM Insurance Group
HM Direct partners with HM Insurance Group

[More News](#)

[Home](#) [Contact Us](#) [Privacy](#)

Q. Does my coverage meet MCC?

Q. When does MCC go into effect?

[View Answers](#)

third party administrator, and a managing general underwriter.

[Learn More](#)

MA License No. 1812179

© 2009 HM Direct. All Rights Reserved

Plan Service Agreement

EMPLOYER DATA

1. Full Legal Business Name: KC Precision Machining, Inc.
2. Street Address: 23 Old Right Road City: Ipswich State: MA Zip: 1938
3. Mailing address (if different): _____ City: _____ State: _____ Zip: _____
County: Essex Phone No. 9783568900 Fax No.: 9783568899
4. Nature of Business: Industrial and Commercial Machinery SIC Code: 3599
5. Federal Tax ID No.: 04-3539565
6. Administrative Contact Person: Pam Casey (e-mail address:) pcasey.kcprecision@verizon.net
7. Executive Contact Person: William Casey (e-mail address:)
8. HIPAA Privacy Information Contact Person: _____
9. Names/Addresses of subsidiaries/affiliates & other locations: _____
10. Yes No If subsidiaries are included, do you want separate bills sent to each of these subsidiaries/affiliates?
11. Plan Administrator: William Casey
12. Legal name of the plan: KC Precision Machining, Inc. Employee Health Plan
13. Yes No Is the plan maintained through a trust? If yes, list name and business address of all trustees. _____
14. Yes No Is this group a government agency or church group?
15. Yes No Is the Plan subject to collective bargaining? If yes, union name: _____ Exp. Date: _____
16. Name of person for service of legal process: William Casey
17. Fiscal Year Ending: 9/30/2008
18. Plan Anniversary: 8/1/2008
19. _____ % of employer contribution toward total employee fixed cost (HMA Administrators, LLC. requires the employer to contribute a minimum of 50% of the single contribution of the lowest cost plan offered). The Excess Loss Policy covers the Employer and not the Employees and Dependents. Therefore, payment of the excess loss premium must be made solely from the Employer's general account and should not be made from any account containing Plan Assets or employee contributions. The Employer must contribute 100% of the Employee and Dependent Health Plan Fixed Costs and at least 25% of the cost of any life, accidental death and dismemberment, and weekly indemnity insurance.
20. List prior insurance carrier or Third Party Administrator (TPA): BCBS
- a. MEDICAL Current group health plan (check one): fully insured self funded
- If you answer yes to any of the above questions, please provide a copy of your most recent & one-year prior billing statement.
21. Name of worker's compensation carrier: Peerless
22. Yes No Are any employees NOT covered by worker's compensation? If yes, give names of employees.
23. Yes No Are you subject to COBRA? (You are subject to COBRA if you employed at least 20 full or part-time employees on at least 50% of the working days during the previous calendar year.)



24. Eligible employees are those employees listed on the Employer's Quarterly Wage Report and include only full-time employees working for a salary or wage at least 30 hours per week or 120 hours per month. Persons on COBRA and persons in their COBRA election period are also eligible. Retirees are not eligible. Eligible dependents are the employee's legally married spouse and the employee's unmarried naturally born children, stepchildren or legally adopted children, who rely on the employee for at least half of their support and maintenance and who are less than 19 years old (or less than 25 years old if enrolled as a full-time student.) Eligible Employees and their Dependents must be resident citizens of the USA or Legal Aliens with legal permission to reside and work in the USA. Please be advised that medical telephone interviews may be conducted.

A. Please list below any persons on COBRA or any persons in their COBRA election period at this time or indicate "None".

Name	Nature of COBRA Qualifying Event	Date COBRA began	Date COBRA will end

B. Please list below any employees not at work due to Total & Permanent or Temporary disability at this time or indicate "None".

Name	Nature of Disability	Date of Disability	Date expected to return

C. Please list below any employees that the Employer considers full-time employees that are not shown on the Employer's most recent Quarterly Wage Report (for example: owners, new hires, approved leaves of absence, temporary layoff, indefinite layoff, part-time, or seasonal) or indicate NONE.

Name	Reason(s) Employer considers them full-time employees

D. Has any individual that is to be covered been absent from work for 10 or more days in the past 12 months due to a medical condition; do any of them have a chronic or ongoing condition; do any of them have test results pending; or have any of them been advised that treatment, tests, hospitalization or surgery is needed (including existing pregnancies & due dates)? NO YES (please answer the following :)

Name	Condition (s) and comments

EMPLOYEE DATA

- Total number of full-time active employees: _____
- Total number of eligible employees: _____
- Total number of enrolling employees: _____

4. Employee probationary period: 90 days 180 days 270 days
 (Six months is the stop loss requirement)
 Rehires and New Enrollees must 365 days Other please explain in the Special Requests section below.
 go through underwriting.

5. Employee effective date: First of month after probationary period.

6. Employee termination date: Immediate

7. Yes No Does current health insurer extend coverage for disabilities after termination date? If yes, provide copy of policy and/or employee certificate.

8. Do you have a Section 125 Premium Only Plan? Yes No Do you want to adopt one? Yes No

If the Employer requires employees to pay any part of the cost of any coverage, then 75% of total eligible employees and dependents must enroll in that coverage. For this calculation, total eligible employees and dependents exclude those with any similar coverage elsewhere, exclude employees in their waiting period and exclude persons on COBRA and persons in their COBRA election period. However, the total number of covered medical employees cannot be less than 60% of the total number of eligible employees including those with similar coverage elsewhere. A waiting period is the time that an eligible employee and their dependents must wait before coverage begins. The waiting period must be in months and cannot exceed 12 months. Coverage will begin the first of the month following the waiting period.

INITIAL PLAN SELECTIONS

The benefits of your Medical plan, Dental plan and any other ancillary products are as stated on the Sign-Off Sheet presented to you by your agent and which was signed by you and is incorporated by reference and made a part of this document.

Stop Loss Policy written by HM Life Insurance Company, Inc.

SPECIAL REQUESTS (subject to written approval by HMA Administrators, LLC.)

Group has a 90 day waiting period and a plan will be provided for new hires for this purpose if an administrative exception is not granted for stop loss coverage for new hires.

Yes the Group wants to provide coverage for dependent children of MA residents living at home with parents pursuant to Chapter 58 of the Acts of 2006- An act of Promoting Access to Affordable, Quality, Accountable Health Care.

PLAN SERVICE AGREEMENT

EMPLOYER has established a self-funded employee welfare benefit plan (hereinafter referred to as "Plan") as the health benefit plan for certain employees and their dependents (the terms of such plan are contained in the self-funded plan document). HMA Administrators, LLC. (HMA) has been contracted by the Plan Sponsor as an independent contractor to perform certain specific and limited administrative services for the PLAN, including processing of claims. The following has been agreed to by the Plan sponsor and HMA.

HMA

HMA Administrators, LLC. -

1. Agrees to provide the following services for the monthly service/billing fees:
 - Update employee enrollment information
 - Print ID cards for new or existing plan participants
 - Perform managed care services
 - Adjudication services including coordination of benefits
 - Investigate third party liability
 - Subrogation to recover claims expenses, excluding any legal fees
 - Issue periodic routine reports
 - Assist in the preparation of Summary Plan Description (SPD) language
 - Provide HIPAA Certificates of Credible Coverage
2. Is responsible for:
 - Processing claims for PLAN benefits according to the terms and provisions of the SPD, using its established claim adjudication procedures
3. Shall arrange for:
 - The purchase of excess loss insurance for the Plan Sponsor and payment of any premiums from funds provided by the Plan.
4. Shall maintain:
 - A fidelity bond for its employees who may collect, handle, or disburse PLAN funds in the appropriate amount as required by ERISA
5. May
 - Pursue subrogation claims in the manner it deems prudent
6. May have
 - Contracted with or have access to a network of designated providers. Some or all of those providers shall be available to provide health services under the PLAN to plan participants. HMA makes no representations or promises regarding continued availability of any particular provider or network nor does HMA make any warranties or representation as to compensation arrangements between these networks and designated providers. HMA may in its sole discretion make deletions from or additions to the list of designated providers or networks.
7. Is authorized

- To do all things it deems necessary or convenient to carry out the terms and purposes of the PLAN
8. May refer to
 - The Plan Sponsor for determination of any question HMA deems necessary, including any disputed claims after the appeal process and questions of eligibility or entitlement to coverage except in the case of misrepresentation

THE PLAN SPONSOR

The Plan Sponsor -

1. Agrees that upon acceptance of this agreement by HMA, the employee benefit plans proposed by HMA and selected by the Plan Sponsor under the Plan Selections section of this Agreement shall be adopted by the employer and will be the basis for the administration of the Employer's employee benefit plan.
2. Shall promptly provide HMA necessary information including, but not limited to:
 - Completed enrollment forms
 - Any changes in participation
 - Creditable coverage documents for eligible employees
 - Occurrence of Qualifying Events
3. Shall assist in and cooperate with
 - Enrollment and settlement of claim benefits
4. Shall comply with
 - All applicable state and federal laws and regulations affecting the PLAN and Plan Sponsor.
5. Is responsible for
 - All COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) notification and all related election notices. It is the responsibility of the Plan Sponsor to distribute COBRA Notification and Election Forms to all employees who are presently enrolled in the PLAN. If COBRA applies, the Plan Sponsor must so indicate on the COBRA Rider attached hereto in which case, HMA will be responsible for appropriate notices and providing COBRA services. The Plan Sponsor is responsible for timely reporting qualifying events to HMA. HMA may rely without qualification on such information provided by the Plan Sponsor.

6. Is responsible for
 - Expenses under the PLAN except for those assumed by HMA in this agreement
7. Recognizes that
 - HMA does not insure or underwrite the liability of the Plan Sponsor.
8. Is responsible for
 - Furnishing SPDs, communicating PLAN changes, notification of termination of coverage, and notification of inadequate funding to plan participants, pursuant to the requirements of ERISA.
9. Is responsible for
 - Providing sufficient information to Plan Sponsor for all filings under the IRS, DOL, and any other state laws or regulations, including state, federal or local filings, reports or returns

FUNDING AND COMPENSATION

The Plan Sponsor -

1. Shall provide:
 - Funds for benefit payment by the first of each month as required by its funding arrangement, and agrees HMA is under no obligation to pay any benefits when the Plan Sponsor has not provided adequate funds. The Plan Sponsor is financially responsible for all eligible claims incurred while the PLAN is in effect. If necessary funds are not provided, HMA will deny all claims in process and may notify all plan participants.
2. Shall compensate:
 - HMA for fixed costs set forth in the monthly billing statement, which includes fees for services rendered and premium for the Plan Sponsor's excess loss insurance policy, by the first of each month.
3. Agrees that:
 - Monies required to pay for fixed costs, administrative fees, and payment of claims shall be deposited in an interest bearing Trust Account ("PLAN BENEFIT ACCOUNT") at Mellon Bank, Boston, MA or other reputable banking institution, for the purpose of paying Plan benefits and expenses in accordance with this agreement, or as otherwise directed by Plan Sponsor. HMA shall account for all receipts and disbursements to and from the TRUST ACCOUNT. HMA may aggregate Plan Sponsor's contributions to the PLAN BENEFIT ACCOUNT in a common account for investment and claims paying purposes provided those contributions shall only be disbursed for the PLAN and pursuant to this agreement. Until 3 months after termination of this agreement, interest shall be credited to the PLAN's account in an amount determined by calculating the PLAN account's pro rata share of the interest earned by the common account based upon the PLAN account's average daily book balance.
 - Funds received from Plan Sponsor under this Agreement and not deposited into the PLAN BENEFIT ACCOUNT may be used to pay for services rendered by HMA and for excess loss insurance; administrative costs will be paid first, and any monies owed to the ~~excess loss carrier will be paid second.~~
 - Rebates on pharmacy claims will be used to reduce the cost of covered prescriptions at the point of sale
4. Shall

Upon notification by HMA, investigate and correct any allegation of error in compensation paid.

5. Shall be responsible
 - If, during the operation of the PLAN or following termination of the PLAN, the federal government, government of any state, or any political subdivision, or any instrumentality of either, shall assess any tax, fee, or claim against the PLAN, Plan Sponsor, or HMA, payment shall be the responsibility of the Plan Sponsor and may be charged to the PLAN.

OTHER PROVISIONS

1. The following will be provided by HMA on a "fee-for-service" basis when applicable and when requested by Plan Sponsor:
 - COBRA administration
 - Special reports as requested
 - Investigation of extraordinary claims
 - Pharmacy Benefits Management
 - Utilization Review, Disease Management, & Case Management
 - Preparation of Form 5500 and other filings required by State or Federal laws
 - Processing and Payment of Claims during Run Out Period
2. Plan Expense
 - As long as HMA has exercised good faith, it shall not be required to reimburse the PLAN for incorrect payments, but will exercise its best efforts to obtain recovery of, or adjustment for such payments. Such payments shall be deemed a PLAN expense.
 - Nothing herein shall limit the Plan Sponsor's right to seek recovery from or commence an action against any party receiving payments to which it was not entitled.
3. Hold Harmless
 - The Plan Sponsor will hold HMA harmless from any and all losses, costs, fines, penalties, judgments, or damages of any kind including attorney's fees in connection with HMA performing its responsibilities under this agreement, provided HMA acts within its scope of authority and in good faith.
 - HMA will hold the Plan Sponsor harmless from all losses and damages incurred as the result of bad faith or intentional wrongful acts committed by HMA, or its employees while performing its responsibilities under this Agreement.
4. Severability

The provisions of this Agreement are severable. If any provision of this Agreement is invalid by law, it will not affect any other provision of the Agreement.

HIPAA BUSINESS ASSOCIATES

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,464 *et seq.* (Dec. 28, 2000) (hereinafter the "HIPAA Privacy Rule"), EMPLOYER (in this section referred to as the "Covered Entity" and HMA (in this section referred to as the "Business Associate") wish to address the requirements of the HIPAA Privacy Rule with respect to "business associates," as that term is defined in the HIPAA Privacy Rule. Specifically, this portion of this agreement is intended to ensure that the Business Associate will establish and implement appropriate safeguards (including certain administrative requirements) for "Protected Health Information" the Business Associate may create, receive, use, or disclose in connection with the functions, activities, or services (collectively "services") to be provided by Business Associate to Covered Entity pursuant to this agreement. The Parties acknowledge and agree that in connection with the services to be

provided; Business Associate will create, receive, use or disclose Protected Health Information. As set forth in the HIPAA Privacy Rule and as used herein, Protected Health Information ("PHI") is defined as individually identifiable health information maintained or transmitted in any form or medium, including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that relate to: (i) the past, present, or future physical or mental health or condition of an individual; (ii) the provision of health care to an individual; or (iii) the past, present, or future payment for the provision of health care to an individual. PHI does not include health information that has been de-identified in accordance with the standards for de-identification provided for in the HIPAA Privacy Rule.

In connection with Business Associate's creation, receipt, use or disclosure of PHI, Business Associate and Covered Entity agree as follows:

GENERAL TERMS

This portion of the agreement shall become effective on the effective date of this agreement. All capitalized terms of this portion of the agreement shall have the meanings set forth in the HIPAA Privacy Rule, unless otherwise defined herein. In the event of an inconsistency between the provisions of this portion of the Agreement and the mandatory terms of the HIPAA Privacy Rule, as may be expressly amended from time to time by the Department of Health and Human Services (HHS) or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the Parties, the interpretation of HHS, such court or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence. Where provisions of this portion of the Agreement are different from those mandated by the HIPAA Privacy Rule, but are nonetheless permitted by the Rule, the provisions of this Agreement shall control. Except as expressly provided in the HIPAA Privacy Rule or this portion of the Agreement, this portion of the Agreement does not create any rights in third parties.

SPECIFIC REQUIREMENTS

a. Business Associate agrees to create, receive, use, or disclose PHI only in a manner that is consistent with this Agreement or the HIPAA Privacy Rule and only in connection with providing the services to Covered Entity. Accordingly, in providing services to or for the Covered Entity, Business Associate, will be permitted to use and disclose PHI for "treatment, payment and health care operations" in accordance with the HIPAA Privacy Rule. Additionally, under the HIPAA Privacy Rule, Business Associate also may use or disclose PHI received by the Business Associate in its capacity as a Business Associate to the Covered Entity if: the use relates to: (1) the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate, or (2) data aggregation services relating to the health care operations of the Covered Entity; or the disclosure of information received in such capacity will be made in connection with a function, responsibility, or service identified in (i)(1), and such disclosure is required by law or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential and the person agrees to notify the Business Associate of any breaches of confidentiality.

b. Business Associate shall include in all contracts with its agents or subcontractors, if such contracts involve the disclosure of PHI to the agents or subcontractors, the same restrictions and conditions on the use and disclosure of PHI that are set forth in this Agreement. Notwithstanding the foregoing, Covered Entity hereby acknowledges that the writing agent(s) identified in Disclosures attached at the end of this Agreement is (are) its agent for the purposes outlined in this business associate agreement. Further, Covered Entity hereby states that said writing agent and/or his agency have entered into a Business Associate Agreement with Covered Entity to perform "treatment, payment and health

care operations" as well as plan management and administrative functions in regard to the plan and that Business Associate is hereby directed to supply said writing agent(s) or his agency whatever PHI he may request be it a verbal or written request. Covered Entity hereby agrees to hold Business Associate harmless from any claims brought against Business Associate based in any manner upon the disclosure of PHI to the writing agent(s) or his agency.

c. Business Associate shall maintain safeguards as necessary to ensure that PHI is not used or disclosed except as provided for by this Agreement.

d. Business Associate shall report to Covered Entity any use or disclosure of PHI that is not provided for in this Agreement.

e. In accordance with 45 C.F.R. § 164.524 of the HIPAA Privacy Rule, Business Associate will make available to those individuals who are subjects of PHI, their PHI in Designated Record Sets by providing the PHI to Covered Entity (who then will share the PHI with the individual), by forwarding the PHI directly to the individual, or by making the PHI available to such individual at a reasonable time and at a reasonable location.

f. Business Associate shall make available the information necessary to provide an accounting of disclosures of PHI as provided for in 45 C.F.R. § 164.528 of the HIPAA Privacy Rule.

g. Business Associate shall make available PHI for amendment and incorporate any amendment to PHI in accordance with 45 C.F.R. § 164.526 of the HIPAA Privacy Rule.

Upon the termination or expiration of this agreement, Business Associate agrees to, at Business Associate's election, destroy the PHI (and retain no copies), or extend the protections of this agreement to such PHI until such time as it is destroyed.

Business Associate shall make available to the HHS or its agents the Business Associate's internal practices, books and records relating to the use and disclosure of PHI.

The Parties agree that Covered Entity shall have the right to terminate this Agreement or seek other remedies if Business Associate violates a material term of this portion of the Agreement.

Security Safeguards. Business Associate has implemented a documented information security program that includes administrative, technical and physical safeguards designed to prevent the accidental or otherwise unauthorized use or disclosure of PHI as follows:

HIPAA Security Standards:

Business Associate Obligations for Securing Electronic Protected Health Information.

The Business Associate obligations set forth below are effective on the effective date of this Agreement.

Definitions:

Electronic Protected Health Information - The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. §160.103, as amended from time to time and generally means protected health information (or "PHI") that is transmitted or maintained in any Electronic media.

Security Incident - The term "Security Incident" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Business Associate Obligations:

Business Associate shall develop, implement, maintain and use appropriate administrative, technical, and physical safeguards ("Safeguards"), that reasonably and appropriately protect the integrity, confidentiality, and availability of, and to prevent non-permitted or violating use or disclosure of, Electronic Protected Health Information created, transmitted, maintained, or received in connection with the services, functions, and/or transactions to be provided under this Agreement.

Business Associate shall document and keep these Safeguards current. These Safeguards shall extend to transmission, processing, and storage of Electronic Protected Health Information. Transmission of Electronic Protected Health Information shall include transportation of storage media, such as magnetic tape, disks or compact disk media, from one location to another. Business Associate shall provide access to, and copies of, documentation regarding such Safeguards upon the written request of Covered Entity.

Business Associate agrees that it has fully implemented the requirements of the HIPAA Security Standards (45 C.F.R. Parts 160, 162, and 164, issued on February 20, 2003) by:

Implementing administrative, physical, and technical safeguards consistent with (and as required by) the HIPAA Security Standards that reasonably protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity.

Access to Health Plan Information Systems:

If Business Associate is provided access to any Health Plan information system or network containing any Electronic PHI, Business Associate agrees to comply with all Health Plan policies for access to and use of information from the system or network.

Reporting and Tracking all Security Incidents:

Business Associate shall report to the Covered Entity any Security Incident that results in (a) unauthorized access, use, disclosure, modification, or destruction of Health Plan's Electronic Protected Health Plan Information, or (b) interference with Business Associate's system operations in Business Associate's information systems, of which Business Associate becomes aware; and

Business Associate shall report to the Covered Entity's Privacy Officer within 14 business days after Business Associate learns of such non-permitted or violating use or disclosure, and the report must meet the format and content requirements imposed by the Covered Entity. For any other Security Incident, Business Associate shall aggregate the data and provide such reports on a quarterly basis, or more frequently upon Covered Entity's request.

Business Associate shall take all reasonable steps to mitigate, to the extent practicable, any harmful effect that is known to Business Associate resulting from a Security Incident, including any reasonable steps recommended by Covered Entity.

Affiliates, Agents, Subsidiaries and Subcontractors. Business Associate shall require that any agents, affiliates, subsidiaries or subcontractors, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agree in writing to the same use and disclosure restrictions imposed on Business Associate by this Section of the Agreement.

This Section does not apply to information that has been de-identified. De-identified information is not PHI or Personal Information, but rather is information that does not identify an individual and with respect to which

there is no reasonable basis to believe that the information can be used to identify an individual. De-identified information created by HMA is and shall be solely owned by HMA.

TERMINATION

1. This Plan Service Agreement may be terminated by the Plan Sponsor or HMA. To terminate this agreement, a written notice must be delivered to the other party not less than 30 days before the effective date of the termination. If such notice is not provided, the Plan Sponsor shall be liable for a late notification fee.
2. HMA shall have the right to terminate the Agreement with five days prior written notice if:
 - The Plan Sponsor does not perform its obligations of PLAN benefit payments; this doesn't relieve the Plan Sponsor of its obligation to reimburse HMA for the payment of PLAN benefits.
 - The Plan Sponsor amends the PLAN without prior written acknowledgement from HMA.
 - The Plan Sponsor fails to pay any fees or charges due and payable under this Agreement
 - In the event the Plan Sponsor fails to pay any amounts due and payable under this Agreement, HMA shall have the right to notify PLAN participants of the termination of this Agreement for such non-payment
3. HMA may terminate this Agreement immediately without
 1. Notice to the Plan Sponsor as of the date:
 - The Plan Sponsor becomes insolvent, bankrupt, or subject to liquidation, receivership, or conservatorship.
 - The excess loss insurance carrier terminates its policy with the Plan Sponsor.
4. If HMA has terminated this Agreement for non-payment of fixed costs the Plan Sponsor may apply for reinstatement according to HMA's terms and at HMA's sole discretion.
5. Termination of this agreement shall not affect the validity, provisions or terms of the PLAN, the PLAN shall continue to be effective until it is cancelled pursuant to its terms.

CLAIMS FUNDING AGREEMENT

Under the terms of my Plan Service Agreement with HMA Administrators, LLC. (HMA) I have agreed to provide funds for benefit payments monthly or more frequently, as required by my banking arrangement, and agree HMA is under no obligation to pay my benefits if I have not provided adequate funds. I understand that I am financially responsible for all eligible claims incurred while my PLAN is in effect. I hereby certify that the Employer will pay 100% of the Employee and Dependent Health Plan Fixed Costs

FUNDING ARRANGEMENTS

Prefunding - Maximum Funding Please check if the Plan has been sold with a Maximum Funding Obligation I will remit my Maximum Monthly Medical/Dental/Vision/Pharmacy Claims Liability, along with my monthly costs by the first of each month to HMA. My funding contribution will be held in an interest bearing account. HMA will process and pay claims periodically. I understand that a Monthly Aggregate Accommodation Rider will be issued in connection with the selection of this option.

Expected Funding - Minimum Funding - Please check if HMA as approved the Plan with Expected or Minimum Funding I will remit the total Fixed Costs paid 100% out of the Employers general funds on a monthly basis. I will provide additional funds for benefit payments monthly or more frequently, upon notification from HMA that additional funding is required. I will remit the amount due to be received by HMA within five (5) days of notification that additional funds are required to pay benefits.

Important: If you do not remit funds as required after notifications by HMA, administration of your PLAN will be terminated. The Employee Retirement Income Security Act (ERISA) places a fiduciary responsibility on the Employer, as Plan Sponsor, to ensure the PLAN is adequately funded. HMA is required to notify the US DOL and may notify all Plan Participants if your claims account is determined to be in jeopardy.

EFFECTIVE DATE/DEPOSIT

(Deposit must include the first month's fixed costs and the first month's maximum claims cost unless Expected/Minimum Funding is approved by HMA.)

Requested effective date: 8/1/2008 Deposit with Application: \$ _____

IMPORTANT: Coverage is not in effect until the undersigned receives written approval from HMA Administrators, LLC. No action is taken on the Application until after all required information is submitted. No person other than an officer of HMA Administrators, LLC. has the authority to bind or alter coverage and the undersigned agrees that any such attempt by an agent is void and not effective. The deposit amount will be returned to the Applicant if the Application is declined.

PAYMENT

The Plan Sponsor shall pay HMA Administrators, Inc. monthly as indicated in the Schedule of Fees and Other Amounts Due attached hereto as amended. All payments are due on the last day of the month prior to the month for which coverage and service are to be effective. Any contributions for funding, stop-loss premium, or administration fees received after the last day of the month for which coverage and services are effective will be considered late and HMA Administrators, LLC. reserves the right to hold all claims payments and authorizations for care until such payments are received.

APPLICANT AGREEMENT

The agent has explained the details of the coverage(s) and I, the undersigned acknowledge reading the entire application, including the Claims Funding Agreement and Plan Services Agreement. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the Applicant and HMA Administrators, LLC. only when the Applicant receives written approval from HMA Administrators, LLC.

Dated on (Month, Day, & Year): 10/21/08

Full Legal Business Name: KC Precision Machining, Inc.

Signature X: William Casey (must be signed by a person authorized to purchase coverage for this firm)

Print Signature and Title: WILLIAM CASEY PRESIDENT

Mail/Deliver Summary & Plan Descriptions (SPDS) to: Employer's business address Employee's Address
After Installation Mail Identifications (ID) cards to: Employer's business address Employee's Address

Producer name: NECHPA Producer name: _____

Social Security Number: 20-1308264 Social Security Number: _____

Street: 7 Wells Avenue, Suite 24 Street: _____

City, State Zip: Newton, MA 02459 City, State Zip: _____

Telephone Number: 617-581-6655 Telephone Number: _____

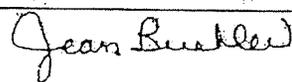
Fax Number: 617-249-0217 Fax Number: _____

Production Split _____ % Production Split _____ %

I have notified the employer not to terminate present coverage until notified in writing by HMA Administrators, LLC of acceptance of this application.

Agent's Signature X  Date: _____

HMA ADMINISTRATORS, LLC.

Effective Date:	Approved & Accepted by:	Jean Buehler, Managing Member	Date:	Signature:	<u></u>
-----------------	-------------------------	-------------------------------	-------	------------	--

Comments: _____

Effective Date:	Approved & Accepted by:		Date:	Signature:	
-----------------	-------------------------	--	-------	------------	--

Comments: _____

Schedule of Fees and Other Amounts Payable
Under Plan Services Agreement

HMA Fees. In consideration for the services rendered by the HMA pursuant to this agreement, Plan Sponsor shall pay to HMA on the first day of each month the following amounts:

<ul style="list-style-type: none"> (1) A service fee per covered member per month in the total amount of (2) A service fee per covered employee for ASO Dental (if applicable) (3) A Premium for Monthly Aggregate Accommodation of \$2.95 per covered employee per month if elected (4) A one-time claims run-in fee per covered employee in the amount of \$0.00 (5) A service fee per covered member per month for Form 5500 services if elected by Plan Sponsor (6) A COBRA Service Fee equal to 2% of the applicable premium (as that term is defined in COBRA) 	<ul style="list-style-type: none"> \$900.00 \$ N/A \$44.25 \$ N/A \$ N/A \$ N/A
--	---

The term "employees" means persons covered under the medical and/or dental benefits of the Plan including a former employee who is covered by virtue of having elected COBRA. Service Fees are included in the minimum costs as outlined in the EMPLOYER'S proposal and the minimum costs include fees for pre-certification, utilization review, medical case management, pharmacy benefits management services, and PPO access, if such services are provided. The fee rates are guaranteed for the first 12 months of this agreement, after which they are subject to change upon 30 days written notice by HMA. EMPLOYER shall be solely responsible for any sales tax levied by any jurisdiction on any of the fees set forth above.

(7) The monthly premium on the Excess Loss Coverage as shown on the Application for Stop Loss Insurance	\$2,989.32
(8) The monthly Employer's Claims Fund obligation	\$3,400.11
TOTAL MONTHLY PAYMENT TO HMA	\$3,777.90

Check the following box only if you are declining the optional 5500 Form Preparation Service.

I Decline The Optional 5500 Form Preparation Service.

DISCLOSURES

The following disclosures are made in compliance with Department of Labor PTE 77-9 (84-24):

- A. Plan assets may be used to purchase insurance coverage in connection with the Plan.
- B. Sales commissions are payable to insurance agents or brokers on administration fees charged by HMA in connection with the sale, on excess loss insurance, life insurance, and weekly indemnity insurance, if any, and other ancillary insurance products as follows, unless otherwise indicated below (percentages are of fixed costs and are approximately the same or less than industry standards):

Compensation for providing service: ___% First year and each renewal year
 Compensation for the sale: ___% First year and each renewal year

NECHPA
NECHPA

The owner of HMA Administrators, LLC. is Health Management Advisors, LLC. It also owns HMA MGU, LLC. an affiliate of HMA Administrators, which provides underwriting services in connection with the PLAN and also reinsures a portion of the insurance you are purchasing. HMA MGU and NECHPA also offer Stop Loss Insurance in connection with your health and dental plans and may receive commissions from HM Life Insurance Company (the Stop Loss Carrier) or another carrier on premiums for said products. Additional amounts may be payable as marketing expense if this case is written directly with an agent through NECHPA. Notwithstanding the foregoing, the final decision regarding any matters relative to the insurance purchased (including claims, eligibility, and premiums) is solely within the decision of the insurance company.

- C. Other compensation, fees, and consideration, if any, received by the writing agent for the provision of services to the Plan are as follows:

General Agent Marketing Fee ___% First year and each renewal year

NECHPA

The sale of this coverage may entitle the writing agent to receive a larger compensation on other business submitted to the insurance company. The undersigned person in his or her capacity as an independent Plan fiduciary with authority to act on behalf of the Plan acknowledges receipt of these disclosures and approves of the purchase of insurance on behalf of the Plan. It is understood that the writing agent is not an agent of HMA.

- D. Compensation for Sale of Insured Ancillary Products: Check Box If Applicable

Life	<input checked="" type="checkbox"/>	___%	First year and each renewal year
AD&D	<input checked="" type="checkbox"/>	___%	First year and each renewal year
STD	<input checked="" type="checkbox"/>	___%	First year and each renewal year
Critical Care	<input checked="" type="checkbox"/>	___%	First year and each renewal year
Hospital Indemnity	<input checked="" type="checkbox"/>	___%	First year and each renewal year
Accident	<input checked="" type="checkbox"/>	___%	First year and each renewal year

NECHPA

COBRA SERVICES RIDER
ONLY APPLICABLE FOR GROUPS SUBJECT TO COBRA

If you answered yes to question 23 on the first page of this Agreement, your group is subject to COBRA and the following is added to this Plan Service Agreement:

HMA COBRA Services. As used herein, the term COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended and the regulations promulgated thereunder. HMA agrees to provide the following services while this agreement is in effect provided: (1) EMPLOYER is subject to federal COBRA continuation laws; and (2) EMPLOYER and persons eligible for COBRA comply with the Administrative Instructions (as used herein, Administrative Instructions refers to any instructions regarding the COBRA service contained in the Service Manual provided to EMPLOYER, including any amendments or changes thereto).

1. To prepare and send via U.S. mail (with proof of mailing) within the time periods stated herein, the notices and forms and payment coupons/bills which are specified herein. Such notices and forms shall be limited to a re-notification of COBRA continuation rights after a Qualifying Event which occurs on or after the effective date of the Plan; an initial or general COBRA notice delivered or given in any means permitted under COBRA to employees and their spouses who become entitled to receive the same after the effective date of the plan; a COBRA election form for qualifying events occurring on or after the effective date of the plan; notice of the unavailability of COBRA continuation in appropriate cases where the alleged first or second qualifying event or disability extension occurred on or after the effective date of the plan; notice of termination of continuation when required by law for those whose continuation terminates after the effective date of the Plan; and (at HMA'S election) issuance of proper payment coupons or bills. Initial or general notices will be sent within 21 days of receipt by HMA of notification by EMPLOYER of a new covered employee or spouse entitled to the same under the Plan. Initial notices will be sent to addresses contained in enrollment forms submitted to HMA or to such other address as EMPLOYER may advise HMA in the manner specified in the Administrative Instructions. EMPLOYER shall be solely responsible for providing initial COBRA notices to those who became covered on or before the effective date of the Plan. The renotification notices and election forms will be sent to persons entitled to receive the same for Qualifying Events occurring after the plan effective date, provided HMA is properly notified of the Qualifying Event within the required time period specified in the Administrative Instructions and provided HMA has received a written determination from EMPLOYER of the current COBRA contributions required by EMPLOYER from such persons to maintain COBRA coverage. The payment coupons or bill will request the current COBRA contributions required by EMPLOYER as advised by EMPLOYER on the forms and in the manner described in the Administrative Instructions and shall be sent within 14 days of receipt of a valid and complete COBRA election form. Notice of the unavailability of COBRA shall be sent within 14 days of receipt by HMA of notice of a purported qualifying event or purported second qualifying event, and shall be sent within 14 days of receipt of notice of a request for disability extension of COBRA for which COBRA continuation is not available.
2. To review and process, pursuant to the requirements of federal law and the Administrative Instructions, all COBRA election forms submitted by persons covered under EMPLOYER'S Plan(s);
3. To maintain records of COBRA notices sent and proof of mailing, and to notify EMPLOYER periodically of the COBRA notices sent and the COBRA elections made by persons covered under the EMPLOYER'S Plan(s);
4. To notify and provide payment coupons/bills to those on COBRA continuation coverage with EMPLOYER at the time the agreement becomes effective within 14 days of receiving notice of such persons, the proper mailing address for each such person, the date their continuation coverage commenced, the date their continuation coverage is scheduled to terminate, the nature of their qualifying event and the proper amount to bill for each such person's COBRA coverage. All such information must be provided in the manner and on the forms designated in the Administrative Instructions; and
5. To deposit in the Plan Benefit Account all amounts (less the fees allowed HMA and any applicable Stop Loss Premiums under this agreement for providing COBRA Services) received for COBRA continuation coverage.

If the provisions of the agreement are continued after the date that it would terminate according to the terms hereof, said continuation shall not apply to COBRA service unless HMA specifically agrees to such a continuation of COBRA Service in a writing which specifically refers to this COBRA SERVICES RIDER to this agreement. Time frames specified herein for performance of COBRA duties outlined herein may be modified or amended by the Administrative Instructions.

Employer COBRA Service. The EMPLOYER agrees to and accepts the following obligations:

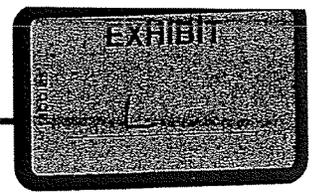
1. EMPLOYER agrees to administer COBRA continuation pursuant to the applicable federal laws and regulations, and pursuant to HMA'S Administrative Instructions (as used herein, Administrative Instructions refers to any instructions regarding the COBRA service contained in the Service Manual provided to EMPLOYER, including any amendments or changes thereto). EMPLOYER agrees that it will annually complete a COBRA verification form and provide the necessary supporting material requested by HMA;
2. EMPLOYER agrees that all written material sent to HMA hereunder shall be sent via registered or certified mail;
3. HMA shall process material received which is not sent via registered or certified mail, however, HMA shall not be responsible or liable for the loss or failure to process any material not sent via registered or certified mail;
4. As Plan Administrator, EMPLOYER shall be ultimately responsible for the determination of those employees and dependents of employees who are eligible for COBRA continuation under the provisions of federal law and for providing HMA with the information required by the Administrative Instructions, and shall timely forward all such necessary information (including but not limited to the date and nature of any purported qualified events applicable to qualified beneficiaries, the last known address of such qualified beneficiaries, any requests for disability extension of COBRA continuation periods, timely notice of newly enrolled employees and spouses and the applicable premium as defined in COBRA) to HMA as set forth in the Administrative Instructions.

6. As Plan Administrator, EMPLOYER shall be responsible for providing HMA with a written determination of the applicable premium required from employees and dependents of employees to maintain COBRA coverage. EMPLOYER hereby directs HMA to increase the applicable premium by the 2% or the 5%, allowed under COBRA.
- EMPLOYER acknowledges that many of HMA's obligations in regard to COBRA Services under this agreement are contingent upon EMPLOYER timely performing its obligations as set forth herein, in the Plan Document, and in the Administrative Instructions and that the failure of EMPLOYER to timely perform its obligations relieves HMA of its duties hereunder or responsibility for not performing said duties.

Miscellaneous COBRA Service.

1. It is understood and agreed that excess loss coverage shall only apply to COBRA continuation coverage to the extent of the minimum requirements of the applicable federal laws; and, only if EMPLOYER complies with the requirements of the law and the COBRA Administrative Instructions provided by HMA;
2. It is understood and agreed that COBRA services will not be provided by HMA in the event: (1) the EMPLOYER or its employee does not submit COBRA forms or notices in the required time periods and on the required forms as specified in the Administrative Instructions; (2) the employee is not required to be provided continuation under the federal laws and regulations; or (3) the EMPLOYER or its employee does not comply with any applicable COBRA federal law, regulation, or the HMA'S COBRA Administrative Instructions as they exist now or as they are hereafter amended; and
3. This service is not retroactive, i.e. it does not apply to persons who experience a Qualifying Event prior to this agreement's effective date (however, HMA will bill such persons subject to the provisions of the Administrative Instructions), nor does it obligate HMA to provide initial notices to employees, or their spouses, employed on or prior to the effective date of the plan.

Pam Casey



From: PamCasey [pam@kcprecision.com]
Sent: Wednesday, December 31, 2008 2:36 PM
To: Ann Engler (E-mail); 'mark.celentano@hmadirect.com'
Subject: Termination Letter

Ann,

We feel the need to terminate our relationship with HMA due to the fact that the product we received was not the product that was described when sold to us. I was told that the HMA plan would mirror our BlueCross plan but be cheaper. I was not told that we would pay for MRIs, lab work, or that we would have to do all the work to get pre-approval for every little thing. This is not what we signed up for. I am also not comfortable with being told that we have to remove someone from the plan and put them on something else until they are "healthy".



Ltr, HMA
Cancellation.doc

Thank you for all of your assistance.

Pam Casey
KC Precision Machining, Inc.
23 Old Right Road
Ipswich, MA 01938
Phone: (978) 356-8900
Fax: (978) 356-8899
E-mail: pam@kcprecision.com
pcasey.kcprecision@verizon.net
Web: www.kcprecision.com



From the U.S. Code Online via GPO Access
 [wais.access.gpo.gov]
 [Laws in effect as of January 3, 2006]
 [CITE: 29USC1182]

TITLE 29--LABOR

CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER I--PROTECTION OF EMPLOYEE BENEFIT RIGHTS

Subtitle B--Regulatory Provisions

part 7--group health plan requirements

Subpart A--Requirements Relating to Portability, Access, and
 Renewability

Sec. 1182. Prohibiting discrimination against individual
 participants and beneficiaries based on health status

(a) In eligibility to enroll

(1) In general

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (A) Health status.
- (B) Medical condition (including both physical and mental illnesses).
- (C) Claims experience.
- (D) Receipt of health care.
- (E) Medical history.
- (F) Genetic information.
- (G) Evidence of insurability (including conditions arising out of acts of domestic violence).
- (H) Disability.

(2) No application to benefits or exclusions

To the extent consistent with section 1181 of this title, paragraph (1) shall not be construed--

- (A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or
- (B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction

For purposes of paragraph (1), rules for eligibility to enroll

under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed--

(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(Pub. L. 93-406, title I, Sec. 702, as added Pub. L. 104-191, title I, Sec. 101(a), Aug. 21, 1996, 110 Stat. 1945.)