Multiple Employer Welfare Arrangements (MEWA)  
Initial Application for Licensure and Initial Application Update

Only use this form for an initial application and for an update to the initial application made pursuant to 18 DE Admin. Code § 1405-4.3 (which requires that if, subsequent to an initial application, changes occur so that the information contained in the filing is no longer accurate, the MEWA, association, or intermediary that made the filing shall, within fifteen days of the date the change is effective, file the changes with the Department), when the update is made within the first year of being a licensed Association or MEWA.

Please complete all fields to avoid delay in processing. Attach additional pages as needed.

☐ This is an initial application  ☐ This is an update to an initial application
(place an “X” beside the information that is being updated and the date on which the information changed)

Information updated with this submission? If yes, place “X” here.

☐  __/__/____  1. Name of Association or MEWA: ________________________________

☐  __/__/____  2. Names and business addresses of all principals, officers, directors, and trustees of the Association or MEWA:
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________
   d. __________________________________________
   e. __________________________________________

☐  __/__/____  3. Names and addresses of the employer members:
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________
   d. __________________________________________
   e. __________________________________________
4. Names and addresses of trustees or other persons responsible for the MEWA's or the Association's operation:

☐ __/__/____

☐ __/__/____

☐ __/__/____

☐ __/__/____

☐ __/__/____

☐ __/__/____

a. ________________________________

b. ________________________________

c. ________________________________

d. ________________________________

e. ________________________________

5. List the contact information for where communications are to be received for the Company:

☐ __/__/____

☐ __/__/____

☐ __/__/____

a. Mailing address: ________________________________

b. Email address: ________________________________

c. Telephone number: ________________________________

6. Set forth the eligibility requirements for membership in the Association or MEWA (add additional pages if more space is needed):

________________________________________________________________

________________________________________________________________

________________________________________________________________

7. Are fees charged for membership in the Association or MEWA;

YES ☐ or NO ☐.

If yes, please provide details of the fee structure, including amounts charged:

________________________________________________________________

8. Are the Association or MEWA’s benefits or coverage fully insured;

YES ☐ or NO ☐.

If no, please provide explanation:

________________________________________________________________

9. List the name of the insurer that insures the Association or MEWA:

________________________________________________________________
10. Does the Association or MEWA meet all of the following requirements of a “bona fide association” set forth in 18 Del. C. § 3506(a)?

☐ __/__/____  a. Has been actively in existence for at least 5 years YES ☐ or NO ☐

☐ __/__/____  b. Has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance YES ☐ or NO ☐

☐ __/__/____  c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee) and clearly so states in all membership and application materials YES ☐ or NO ☐

☐ __/__/____  d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member) and clearly so states in all marketing and application materials YES ☐ or NO ☐

☐ __/__/____  e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association and clearly so states in all marketing and application materials YES ☐ or NO ☐

☐ __/__/____  f. Provides and annually updates information necessary for the Commissioner to determine whether or not an association meets the definition of a bona fide association before qualifying as a bona fide association for the purposes of this chapter. YES ☐ or NO ☐

If no, please provide an explanation:

__________________________________________________________________________
11. Is the insurance policy offered by the Association or MEWA in compliance with the following requirements as set forth in 18 Del. C. § 3506(b)?

☐ / / ___ a. The policy may insure members of such association or associations, employees thereof or employees of members or 1 or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employer YES ☐ or NO ☐

☐ / / ___ b. The premium for the policy shall be paid from funds contributed by the association or associations or by the employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members. YES ☐ or NO ☐

☐ / / ___ c. A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing. YES ☐ or NO ☐

If no, please provide an explanation:
________________________________________________________________

12. Describe the Association or MEWA’s membership requirements:

☐ / / ___

13. List the names, addresses, and qualifications of persons who will solicit, negotiate, procure, or effect applications for coverage with the association or MEWA:

Name: _______________________________________________________
Address: _____________________________________________________
Qualifications_________________________________________________

Name: _______________________________________________________
Address: _____________________________________________________
Qualifications_________________________________________________
14. List the names and addresses of all administrators and organizations, including third party administrators or intermediaries, responsible for the operation of the Association or MEWA that complies with the following:

- The Association or MEWA contact shall be the person responsible for filing all applicable forms and changes in information with the Department:
  - Name: ___________________________________________
  - Address: _________________________________________
  - Role: TPA ☐, Intermediary ☐, Other ☐. If other, please specify:

- The regulatory contact shall be the person responsible for receiving notice of laws regulations, bulletins, and the like that may affect the plan. Complete and attach Form D2.

  - Name: ___________________________________________
  - Address: _________________________________________
  - Role: TPA ☐, Intermediary ☐, Other ☐. If other, please specify: __________________________________________

15. Does the insurer offering the health benefit plan to the association or a MEWA shall guarantee acceptance of all persons within the association or MEWA and their dependents as required by 18 DE Admin. Code § 7.5? YES ☐ or NO ☐

16. Does the health benefit plan provide all of the benefits listed in 18 DE Admin. Code § 8.0? YES ☐ or NO ☐

17. Does the health benefit plan meet all of the membership requirements of 18 DE Admin. Code § 9.0? YES ☐ or NO ☐

18. Does the health benefit plan comply with the notice requirements of 18 DE Admin. Code § 10.0? YES ☐ or NO ☐

19. Does the health benefit plan comply with the enrollment requirements in 18 DE Admin. Code § 11.0 and 18 Del. C. § 3571J? YES ☐ or NO ☐
20. Attach a copy of each of the following documents:

a. Any policy or contract describing the benefits offered by the Association or MEWA.

b. The organizational documents of the Association or MEWA, including but not limited to:
   i. Articles of incorporation;
   ii. By-laws;
   iii. Trust instrument;

c. The Association or MEWA's certificate of good standing from the state in which association or MEWA is registered as a business;

d. Any document executed by an employer to become a member of the Association, including application for membership in the association;

e. The biographical affidavits for all trustees, officers, directors, and other members of the Association or MEWA's governing body who are responsible for the operation of the Association or MEWA;

f. All current policies or contracts of insurance issued to the Association or MEWA that provide coverage for health care benefits and services to be offered in Delaware;

g. All current contracts between the Association or MEWA and insurers to provide coverage for health care benefits and services to be offered in Delaware;

h. All current advertising and marketing materials used by the association or MEWA;

i. A completed UCAA Form 12 (registered agent for service of process form).

j. The most recent audited financial statement as defined in 18 DE Admin. Code § 1405-12.0.

k. The most recent M-1 form as filed with United States Department of Labor.

l. Documentation reflecting a minimum surplus that is not less than $500,000, regardless of whether the insurer directly bills certificate holders for premiums on behalf of the Association or MEWA or if the Association or MEWA bills its members for premiums and remits the premiums to the insurer.

m. A certified copy of a surety bond sufficient to cover 20% of the Association’s or MEWA’s annual premium for Delaware members that is in a form to be approved by the Commissioner and has been issued by an insurer or surety licensed to transact such business in Delaware, or by a surplus lines insurer on Delaware's approved list.
21. Send the completed application and all supporting documents electronically to BERG@delaware.gov.

22. Remit filing fee in the amount of $1000 by check, made payable to Delaware Department of Insurance (checks with an incorrect payee will be rejected).

   **Mail to:**
   Delaware Department of Insurance
   Attn: BERG
   1351 W. North St., Ste 101
   Dover, DE 19904

   Note that the time frames for Department review set forth in 18 DE. Admin. Code § 1405-4.4 and 4.5 will begin on the date that the Department receives the applicant’s check, not from the date that the Department receives the application by email.

   The Undersigned hereby swear and affirm that the foregoing statements and information regarding ________________________________________________are true and correct.

   (Name of Association/MEWA)

   ________________________________  __________________
   Signature of Officer, Director, or Trustee  Date

   ________________________________
   Printed Name

   State of ) )
   )ss:
   County of )

   Sworn before me this _____ day of ________________,_____

   ____________________________________________
   Notary Public

   My Commission Expires: ________
The Undersigned hereby swear and affirm that the foregoing statements and information regarding ________________________________ are true and correct.

(Name of Association/MEWA)

__________________________________  ____________
Signature of Plan Intermediary  Date

__________________________________
Printed Name

State of  )
  )ss:
County of  )

Sworn before me this _____ day of ________________,_____

____________________________________
Notary Public

My Commission Expires: ________