NC DEPARTMENT of INSURANCE

Special Entities Division

Professional Employer Organization Notification of Change in Workers' Compensation Insurance or Health Benefit Plan

Licensee Name:_____

Type of Change

Workers' Compensation Insurance Discontinuance with Replacement
Workers' Compensation Insurance Discontinuance without Replacement
Health Plan Discontinuance without Replacement
Health Plan Discontinuance with Replacement

1. Has the Licensee notified client companies in writing about the discontinuance (and replacement, if applicable) noted above? If “No” attach an explanation
2. Attach a list of the names of all affected client companies. If the change involves workers’ compensation insurance include the company’s Workers’ Compensation Classification Code.

Workers' Compensation

1. Attach evidence of workers' compensation insurance for all affected assigned employees.
2. If the replacement workers’ compensation insurance is procured by the Licensee, is the premium paid by the Licensee commensurate with exposure and anticipated claim experience for all employees covered under policies in the name of the Licensee? If “Yes” attach an executed form PEO-17. If “No” attach an explanation.

Health Benefit Plan

1. In accordance with N.C. Gen. Stat. § 58-89A-115, please provide plan summaries from each carrier and attach an exhibit disclosing the following with respect to any replacement health benefit plan provided by the Licensee for the benefit of its employees assigned to the client companies affected by the change noted above:
    - The type of coverage
    - The identity of each insurer for each type of coverage
    - The amount of benefits provided for each type of coverage and to whom or on whose behalf benefits are to be paid
    - The policy limits on each insurance policy

2. If the Licensee offers to its employees assigned to the client companies named above any health benefit plan that is not fully insured by an authorized insurer, please provide evidence that:
    - The plan utilizes a licensed or registered third party administrator
    - All plan assets, including participant contributions are held in a trust account
    - The plan provides sound reserves as determined by using generally accepted actuarial standards.

Under the penalty of perjury, I affirm that I have reviewed this notification and accompanying information, and to the best of my knowledge and belief it is true, correct, and complete.

_____

Signature of Authorized Individual

_____

Printed Name

_____

Title

_____

Date

State of North Carolina
County of _____

I certify that the following person(s) personally appeared before me this day, each acknowledging to me that he or she signed the foregoing document:

Date: _____

Notary public: _____

Printed name: _____

My commission expires: _____

(Seal)