Employer Election for Payment of Wellness Plan Administrator's Fee

Company Name:____

Authorized Representative:____

Title:____

Address:____

____

Telephone Number:____

Wellness Plan Administrator ("WPA"):______________________________________

WPA Contact: ____

WPA Address: ____

WPA Phone Number: ____

Monthly amount payable to WPA ("WPA Fee"): ___________________________

On behalf of the above-named company, I hereby authorize Patriot Health Insurance Company, Inc. ("Patriot") to pay the Wellness Plan Administrator ("WPA") an amount equal to the WPA Fee. I understand that Patriot will add the WPA Fee to my premium rates for Patriot Signature and Standard Plans health insurance, and that Patriot will pay the WPA Fee to the WPA as and when premium is paid by my company for Patriot Signature and Standard Plan health insurance.

____________________________________ ___________________________

Signature Date

Form 030a

33 South Commercial St.
Manchester, NH 03101

603.296.0312
603.296.0315 Fax