BROKER/ADVISER SERVICES & COMPENSATION DISCLOSURE FORM

Section 202 of the federal Consolidated Appropriations Act of 2021 requires "disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans." Effective for service arrangements entered into or renewed on or after December 27, 2021, a responsible plan fiduciary must obtain from the broker, adviser, or consultant a Services & Compensation Statement that describes the services to be provided to the plan and discloses all direct and indirect compensation related to the health plan. **If the broker or adviser/consultant fails to comply, the employer, as the plan sponsor, must report such failure to the U.S. Department of Labor (DOL). In addition to potential penalties, the employer is also in breach of its fiduciary duties if it hires that broker/adviser.**

This Disclosure Form is designed to protect the plan sponsor by providing full and complete transparency of the total compensation that the broker, adviser, or consultant receives so that you can identify and avoid conflicts of interest and misaligned incentives.

NOTE: When comparing compensation of different brokers/advisers, consider the outcomes and bottom-line results each delivers.

Broker/Adviser/Consultant: _____ **Client:** _____

Brokerage/Advisory Firm: _____ **Plan Year:** _____

SERVICES & DELIVERABLES

DESCRIPTION OF SERVICES TO BE PROVIDED TO THE PLAN

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PROJECTED COST SAVINGS

Medical: $ _____ Pharmacy: $ _____ **TOTAL:** $ _____

REDUCTION OF EMPLOYEE OUT-OF-POCKET COSTS

Previous Year Deductible: $_____ New Deductible: $_____

Previous Year Co-Insurance: _____% New Co-Insurance: _____%

☐ Deductible, Co-Insurance & Co-Payment WAIVED When Employee Follows Medical Team Guidance

COMPENSATION

NOTE: Some fees may be estimates and will vary throughout the course of the year. However, without a significant and unplanned change, they shouldn't vary significantly from estimates.

PRODUCT AND ACCOUNT-SPECIFIC FINANCIAL COMPENSATION

Category	Vendor Name	Effective Date	Compensation Type	Compensation Multiplier	Total Compensation
Medical					
Pharmacy					
Dental					
Vision					
Stop Loss					
Medical Mgmt.					
EAP					
FSA					
Group Life					
AD&D					
LT Disability					
ST Disability					
Cancer					
Critical Illness					
Wellness					
Disease Mgmt.					
Consulting Fees					
Percent of Savings					
Other					
				TOTAL	

NON-ACCOUNT AND NON-PRODUCT SPECIFIC FINANCIAL COMPENSATION

Compensation	Vendor	Compensation Type	Actual or Valued Amount
Contingent/Bonus Commission			
Override Bonus			
Retention Bonus			
Back-End Commission			
Other			
		TOTAL	

ALL OTHER FINANCIAL COMPENSATION, CONFLICTS OF INTEREST, AND PERKS

Compensation Type	Vendor	Specific Type	Actual/Valued Amount	Details
Trips/ Events/Other				
Wholly Owned Product/Service				
Equity or Other Ownership				
Other Stakeholder Type (e.g., Board Membership)				
Coalition/GPO				
Other				
		TOTAL		

ALL NON-FINANCIAL COMPENSATION, CONFLICTS OF INTEREST, AND PERKS

Compensation Type	Specific Type	Details
Conference Attendance		
Preferred-Vendor Panel(s)		
Other		

TOTAL COMPENSATION

Compensation Category	Totals from Above
Product and Account-Specific Financial Compensation	
Non-Account and Non-Product Specific Financial Compensation	
All Other Financial Compensation, Conflicts of Interest, and Perks	
TOTAL COMPENSATION	

CONFIRMATIONS

➔ Please confirm specifically that there are no circumstances in which your individual compensation related to our company's health plan, whether alone or in conjunction with other clients, may vary significantly from the above.

◯ **I CONFIRM** ◯ **I CANNOT CONFIRM**

➔ Please confirm specifically that neither you nor your firm accepts any non-account specific financial compensation from any products, services, or vendors you're recommending, including, but not limited to, contingent or bonus commissions, override or retention bonuses, and back-end commissions.

◯ **I CONFIRM** for myself and my firm ◯ **I CONFIRM** for myself only ◯ **I CANNOT CONFIRM**

(If you cannot confirm for ***both yourself and your firm***, please provide a detailed explanation below)

➔ Please confirm specifically that neither you nor your firm has any other financial or non-financial compensation, potential conflicts of interest, or incentives related to products, services, or vendors you're recommending, including, but not limited to, ownership, equity stakes, revenue/profit sharing, GPO/coalition participation, preferred-vendor panel(s), conferences or trips, or personal relationships.

◯ **I CONFIRM** for myself and my firm ◯ **I CONFIRM** for myself only ◯ **I CANNOT CONFIRM**

(If you cannot confirm for ***both yourself and your firm***, please provide a detailed explanation below)

For the questions above to which you cannot confirm for ***both yourself and your firm***, please provide a detailed explanation, including the source as well as specific, expected, or estimated dollar value, if available. Attach additional pages if necessary.

SIGNATURES

Broker/Advisor/Consultant

I certify that to the best of my knowledge that the above is an accurate description of plan services & deliverables and a complete & meaningful disclosure of my firm's entire compensation related to the medical plan.

Name: _____

Entity: _____

Title: _____

Signed: _____

Date _____

Responsible Plan Fiduciary

I acknowledge that the signed Broker, Adviser, or Consultant has presented and adequately reviewed the above descriptions and disclosures.

Name: _____

Entity: _____

Title: _____

Signed: _____

Date _____