# LIFEX RESEARCH CORPORATION APPLICATION

**Please provide complete and legible information. An incomplete or inaccurate application may affect your consideration for employment status.**

LifeX Research Corporation ("LifeX", "our", "us", "Employer", or "we") is committed to a policy of Equal Employment Opportunity and will not discriminate against an applicant or employee based on race, color, religion, creed, national origin or ancestry, ethnicity, sex (including gender, pregnancy, sexual orientation, and gender identity), age, physical or mental disability, veteran or military status, genetic information, citizenship, marital status or any other legally recognized protected basis under federal, state, or local law. The information collected by this application is solely to determine suitability for employment status, verify identity, and maintain statistics on applicants.

Applicants with disabilities may be entitled to reasonable accommodation under the Americans with Disabilities Act and certain state or local laws. A reasonable accommodation is a change in the way things are normally done which will ensure an equal employment opportunity without imposing undue hardship on LifeX Research Corporation. Please inform the company's personnel representative if you need assistance completing this application or to otherwise participate in the application process.

## Job Description: Research Associate

The Research Associate (herein referred to as "Research Associate", "RA", or "employee" interchangeably) provides data insights through questionnaires, surveys and data gathered through third party administrators and for benefit plans and other third party analytics companies related to topics that LifeX and its vendors and third affiliates deems important in understanding individuals and their dependents' behavior related to health, wellness, health care, lifestyle, exercise, diet, personal habits, outcomes from health coaching and guidance, the effects of supplements and medication including, but not limited to prescription medicine, wellness supplements, regenerative supplements and treatments, and data related to medical claims and services rendered, and the effects of data insights related to health and wellness. The foregoing list is not intended to be an all-inclusive or exhaustive list of data points gathered on and from Research Associates but rather is a general overview of the types of information collected by LifeX from its Research Associates. This role is also called upon to provide general insights that better inform service consumption and predictive modeling. This position requires you to attest to the truthfulness and accuracy of all information provided to the Employer (including any agents, contractors, affiliates, or other third parties engaged by Employer (collectively "Employer Affiliates")) during the pre-employment and employment relationship, including this Employment Application, as well as in any other documents completed and submitted to Employer or Employer Affiliates . You will be required to, among other things, accurately, truthfully, and timely complete surveys at various times throughout the year in a timely manner when assigned to you by Employer. Your responses are valuable to LifeX. New Research Associate's will be evaluated by management within the first ninety (90) days of employment (the "Probationary Period") during which time Employer will determine if the Research Associate has met Employer's requirements to continue part-time work as a Research Associate. You acknowledge that Employer may determine in its sole and absolute discretion whether or not a Research Associate has met Employer's needs and may terminate any Research Associate's employment status at any time for any lawful reason.

If accepted for employment at LifeX Research, you as the Employee will be required to complete employee onboarding documents required by Employer including, but not limited to, form W4, form I9 (and related / required documents, and submittal of a direct deposit form(s) or mailing address to receive physical checks for payment by Employer prior to being officially admitted as an employee of LifeX.

The role of the Research Associate involves completing ONE (1) activity at a maximum each month. Activities will be assigned to Research Associates which will have designated completion times of 15 minutes, 30 minutes, 45 minutes, and 60 minutes. Research Associates will be paid forty (40) dollars per hour ($40.00) and will be paid pro

rata hourly basis. Research Associates will not be paid for work that they were not assigned nor permitted to engage in or complete. If employed by LifeX, you as the Research Associate agree to only perform those tasks assigned to them by LifeX and to not engage in or spend any time in excess of the assigned or allotted by LifeX.

## Contact & Eligibility Information

First Name: Last Name: Middle Initial:
Address:

Are you legally authorized to work in the United States? ☐ Yes ☐ No

Do you now, or will you in the future, require immigration sponsorship for work authorization, *e.g.,* H-IB? ☐ Yes ☐ No
(Upon hire, verification will be required consistent with federal law.)

Are you at least 18 years of age? ☐ Yes ☐ No`
(If no, you may be required to provide authorization to work).

## Education Information

Indicate the ***highest level*** of education you have achieved:

- Elementary and Secondary ☐ 8 or under ☐ 9 ☐ 10 ☐ 11 ☐ 12
  Degree ☐ Yes ☐ No
  GED ☐ Yes ☐ No

- College Undergraduate: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
  Degree ☐ Yes ☐ No
  Type: ☐ BA ☐ BS ☐ Other, identify:
- Graduate School (*e.g.,* Masters) ☐ Yes ☐ No
  Type: ☐ MA ☐ MS ☐ MBA ☐ Other, identify
- Doctorate (*e.g.,* MD, PhD, DO, JD) ☐ Yes ☐ No
  Type: ☐ MD ☐ PhD ☐ DO ☐ JD ☐ DDS ☐ DBA ☐ Other, identify

Are you currently in and education program: ☐ Yes ☐ No

## Licenses, Certifications & Registrations

I possess all the following active licenses:

☐ Drivers
☐ Commercial Drivers
☐ Real Estate
☐ Dentist
☐ Cosmetology/Barber
☐ Architectural
☐ Social Work
☐ Electrician

☐ Medical
☐ Nursing
☐ Legal
☐ Dentist
☐ Plumbing
☐ Pilot
☐ Other, identify

Identify all certifications and registrations you possess:

_**Initial** By initialing, Applicant certifies you are not applying on behalf any other individuals other than those who are considered dependents.

_**Initial** By initialing, Applicant acknowledges and agrees that, if employed by Company, Applicant will also be subject to any additional employment policies/terms and conditions as implemented by the Company from time to time, which policies will be published at LifeXresearch.com/termsandconditions.

# Health Plan Enrollment

## Introduction

LifeX Research Corporation, including its successors or assigns ("LifeX Research Corporation", "LifeX", "our", "us" or "we") is proud to offer you a number of available health plans (each a "Plan" and, collectively, the "Plans") to choose from as an employee of LifeX Research Corporation Management. The health and wellness benefits offered by LifeX Research Corporation are based on a managed care model (the "Program"). This agreement (the "Agreement") describes and summarizes the key components of various Plans offered by LifeX through TPA Exchange. ("TPAX").

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

*Please read all 11 items below carefully. You will be required to attest to your understanding and agreement to all of them.*

1. By providing information to LifeX via this application process or at any point during your term as an employee, you hereby authorize to use and/or disclose the protected health information about you described below ("PHI") to the medical providers, partners of LifeX, and LifeX itself, based on you and your overall health, health care provider(s), specific medication(s), benefit plan or PBM, pharmacy, and/or health care system.

2. The PHI that may be used and/or disclosed is all PHI submitted by you, which may include all past, present, and future periods of health care information.

3. The PHI may be used and/or disclosed for the following purpose: Any information, including non-public personal health information, such as name, address and social security number, including detailed protected health information provided will be used for providing a risk assessment to the health Plan to provide a health care benefit. The applicable health Plan's actuary is a legally contracted underwriter acting as a Business Associate to the Program and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. The applicable health Plan's actuary and underwriter will not sell, license, transmit or disclose this information outside of their offices except as: a) necessary for them to provide the services on behalf of the health plan, b) implicitly authorized by you, c) necessary for backup documentation purposes, or d) required by law.

4. Notwithstanding anything stated in #3 above, I understand that any information that I provide to LifeX will be de-identified, meaning removing certain elements from your PHI, such as your name, address, telephone

number and member identification number so that we may use it to conduct certain business activities; for example, to create summary reports and to analyze and monitor industry trends, to conduct research, to analyze and improve our products, and to share with third parties. As it relates to sharing of de-identified data with third parties, you hereby authorize LifeX to sell, license, lease, or otherwise use your de-identified PHI and other data for commercial means which may result in LifeX realizing revenue and/or a profit from the use of such data. By signing this application and health plan enrollment for you are hereby consenting to LifeX's use of such data for any means it deems reasonable in LifeX's sole discretion so long as such data is de-identified.

5. This Authorization is valid beginning on the date and time that you submit this Application and expires upon your request or upon your termination as an employee of LifeX, whichever comes first.

6. The entities receiving health information under this authorization will not receive direct or indirect remuneration in exchange for disclosing the health information.

7. I understand that, as set forth in the Privacy Notice I have the right to revoke this authorization, in writing, at any time, except to the extent that any entities have acted in reliance upon it, by sending written notification to: legal@lifexresearch.com

8. I understand I have the right to refuse this Authorization but will not be able to complete this Application.

9. I understand that it is a pre-condition for health plan inclusion, that I contribute to the ongoing development of LifeX's research initiatives aimed at improving the health and wellbeing of the Program, such research will include, among other things, the collection of my health and wellness data, medical claims data, effects of health and wellness coaching on individuals and on groups when such data is aggregated with other individuals, both positive and adverse effects of lifestyle, changes in lifestyle, impacts that certain medications or supplements may have overall health, and other data points related to health and wellness.

10. I understand that PHI used or disclosed pursuant to this Authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

11. I have read the HIPAA Notice of Privacy Practices.

**_____ By initialing, you agree to the terms of this Authorization.**

## Applicant Representations and Warranties

*Please read all 7 items below carefully as you will be required to initial or sign at the bottom of this section attesting to your understanding and agreement to all of them.*

I have read and understand that the Plans exclude specialty medications.

*I understand that the information contained in this Application is for information purposes only and does not guarantee or bind TPAX to provide health benefits coverage.*

I consent to being contacted with certain non-emergency, automated, pre-recorded or other text message communications from TPAX, XBG and partners under the Telephone Consumer Protection Act (TCPA). By providing your initials, you authorize us and our affiliates to contact you using the phone number listed on this Application regarding your employment, onboarding, benefits, and related communications. Message frequency varies. Standard message and data rates may apply. You may opt out of text messages at any time by replying STOP and request assistance by replying HELP.

I understand that both LifeX and TPAX gathers this information for, among other things, statistical and actuarial uses and other business objectives.

*That as a prospective Plan member, I have the right to request restrictions on how my protected health information is used, and that either TPAX or LifeX is not required by law to grant this request, but if the request is granted, LifeX and TPAX are bound by this Agreement. I also understand that I have the right to revoke this consent in writing, except to the extent LifeX or TPAX has already used or disclosed the protected health information in reliance upon my consent. I further understand that both TPAX and LifeX will notify the member of any health or enrollment-related changes that occur after signing this form, up to the coverage effective date.*

I understand that only the signatory to this Agreement, and no dependent or other Plan member associated with signatory, is admitted as an employee of LifeX, its successors and assigns.

By signing this Application, I understand the following: I certify that the statements are true and correct to the best of my knowledge. That knowingly false information submitted on this form constitutes fraud or intentional misrepresentation of material fact, and LifeX may rescind healthcare coverage and deny or terminate employment.

**By initialing above and signing below, you certify under penalty and perjury of law that the seven foregoing representation and warranties are true and accurate and that you expressly agree to all of the provisions contained in each of the seven sections above.**

**Signature**: _____ **Date:**

## Medication Disclosures

The plans discussed below specifically exclude **all specialty medications**, including human growth hormones. Specialty medications are defined broadly as medications classified as **high-cost, high complexity and/or high touch**. Specialty drugs are often **biologics** — "drugs derived from living cells" that are injectable or infused (although some are oral medications).

Due to this exclusion, the plans work with a 3rd party vendor that can source medication through foundational assistance (i.e. "PAP") based on qualifying set of criteria including income and household size.

For those medications that are on this formulary, LifeX reserves the right to use means other than retail fill in the provision of your medications. It is important to consider whether this policy will meet your needs if you are currently or anticipate taking specialty medications. Further, it is **highly advised** that the employee / potential Plan member(s) (including dependents) discuss available medications and related coverage with the Plan provider prior to executing and submitting this Application and related Health Plan Enrollment Form.

## Plan Type & Participant Coverage

**Applicant:** Please indicate the Coverage you are electing.

**Select One Only**: ☐ Self ☐ Self + Spouse ☐ Self + Children ☐ Family

**Applicant:** Please indicate the Plan Type you are electing:

**Select One Only**:

☐ PHCS PPO ☐ MAGNACARE

**Select One Only:**

| Plan Type | Plan Deductible |
|---|---|
| ☐ $250 VL Plan (Grandfathered in) | $250 Individual Deductible \| $500 Family Deductible |
| ☐ $500 VL Plan | $500 Individual Deductible \| $1,000 Family Deductible |
| ☐ $750 VL Plan | $750 Individual Deductible \| $1500 Family Deductible |
| ☐ $1,000 VL Plan | $1,000 Individual Deductible \| $2,000 Family Deductible |
| ☐ $1,500 VL Plan | $1,500 Individual Deductible \| $3,000 Family Deductible |
| ☐ $1,000 MM Plan | $1,000 Individual Deductible \| $2,000 Family Deductible |
| ☐ $2,500 MM Plan | $2,500 Individual Deductible \| $5,000 Family Deductible |
| ☐ $3,500 MM Plan | $3,500 Individual Deductible \| $7,000 Family Deductible |
| ☐ $4,900 MM Plan | $4,900 Individual Deductible \| $9,800 Family Deductible |
| ☐ $7,250 MM Plan | $7,250 Individual Deductible \| $14,500 Family Deductible |
| ☐ $3,500 HSA | $3,500 Individual Deductible \| $7,000 Family Deductible |
| ☐ $5,000 HSA | $5,000 Individual Deductible \| $10,000 Family Deductible |
| ☐ $8,300 HSA | $8,300 Individual Deductible \| $16,600 Family Deductible |
| ☐ $500 PPO Plan | $500 Individual Deductible \| $1,000 Family Deductible |
| ☐ $750 PPO Plan | $750 Individual Deductible \| $1500 Family Deductible |
| ☐ $1,000 PPO Plan | $1,000 Individual Deductible \| $2,000 Family Deductible |
| ☐ $1,500 PPO Plan | $1,500 Individual Deductible \| $3,000 Family Deductible |

***PLEASE NOTE: FOR PLANS THAT HAVE OurLiveDoc as their Pharmacy / pharmacy provider**, these Plans listed above include only a limited number of acute generic medications including many commonly used acute care medications. Some chronic medications may be mail-order only. Members will pay out of pocket at a retail pharmacy for all acute or chronic medications that are not on the Plan Formulary.

I understand that these Plans cover pre-existing conditions and based on my health status, I cannot be discriminated against in any way on that basis. I understand that LifeX, through TPAX, may offer multiple plan design options with various types of coverage limitations, and it is ultimately my responsibility to thoroughly understand the coverage selection I choose. I further understand that false, incomplete, or inaccurate information provided by myself may result in the termination of my coverage or the non-payment of my benefits. Misstatements & omissions made by me on this health application may cause me to lose complete coverage under the Plan.

**Signature**: _____ **Date:**

## PLAN TERMS AND CONDITIONS

### Managed Care

The health and wellness benefits offered by LifeX are based on a managed care model (the "Program") and follow

strict guidelines on the use of evidence-based medicine, Centers of Excellence (COEs) and best in class physicians and hospital systems. The model is focused on enhancing the clinical outcomes and improving member health, which paradoxically, should lower costs for both the covered members and the Plan.

Not all medications and procedures are covered under this program, and there are many providers and facilities that will fail to meet the rigid, higher quality standards of the model. To avoid any disruption of current or planned medical treatments, please answer the following questions as honestly and completely as possible. This information will be used to determine how the Plan can meet your medical needs with the least amount of disruption or interruption of service.

I have read and understand the information set forth above: ☐ Yes

I understand that these Plans cover only disclosed pre-existing conditions and based on my health status, I cannot be discriminated against in any way based on the information I have submitted. I understand that LifeX may offer multiple plan design options with various types of coverage limitations, and it is ultimately my responsibility to thoroughly understand the coverage selection I choose.

I further understand that false, incomplete, or inaccurate information provided by myself may result in the termination of my coverage or the non-payment of my benefits.

Misstatements & omissions made by me on this health application may cause me and any dependents that I may have to lose complete coverage under the Plan.

## Rates & Contract Terms

Once a member is entered into a plan of their choice (the "Plan"), the initial term of that Plan (the "Initial Contract") shall remain in force, as follows:

> **Calendar Year Deductible:** Once a member chooses a Plan with a fixed **Calendar Deductible Year**, the initial term will end on the first December 31st following the initial enrollment month (Effective Date). The deductible will reset on the next January 1st with each subsequent term of 12 months. For example, if a member enrolls in September, their deductible will run for four months and reset on January 1st.

As with all plans, member rates are based on the following:

- Calendar Deductible Year plans will reset on the first of January following the completion of 12 months on the plan.

Employees are construed to include any member who previously lost coverage from the Plan as the result of any failure to remit payment before the end of the grace period. New Deductible Year rates will be presented one (1) month prior to the start of the Deductible Year.

Upon conclusion of an Initial Contract, a member may continue your coverage with the Plan for subsequent periods that are no less than twelve (12) months (the "Renewal Contract"). Unless otherwise modified by the Plan, amounts assessed pursuant to Renewal Contracts remain valid from the ("Renewal Date"). members that remit payment as due on the Renewal Date will be deemed to have accepted the Renewal Contract. Unless otherwise notified by the Plan, members understand and agree that the terms and conditions of Renewal Contracts are the same as those in effect for the Initial Contract. Members agree the Plan reserves the right to adjust rates during Initial and or Renewal Contracts if the claims expense and or Plan utilization exceeds projections.

During Open Enrollment, all Members may choose to change plans. Any change in plans for a member will result in the application of the applicable deductible year.

## Billing & Collections

Unless otherwise agreed to in writing by TPAX, including its successors and assigns, payments for coverage under each of the Plans are due the first day of the month or the day of the month associated with your Effective Date based on your Plan's billing cycle set forth above in the Rates & Contract Terms Section). Any subsequent renewals of coverage shall remain in force for subsequent periods of twelve (12) months unless terminated by the member or TPAX. Payment of money to cover the cost of the Plan shall be remitted to TPAX monthly, subject to the following guidelines for Billing and Collections:

1. By signing this Application, you authorize TPA Exchange ("TPAX") (shown on your credit card as BENEFIT-HP/LIFEX) or any of its contracted partners to:
    a. For initial coverage, immediately charge your credit card or auto-debit you're checking or savings account as indicated on your quote, and
    b. For recurring payments, on or around the 15th of each month for payment of your health care contributions for the following month.
2. By signing this Agreement, you acknowledge that you understand that this authorization will remain in effect until you cancel it in writing, and you agree to notify both TPAX or its contracted partners responsible for billing you in writing of any changes in your account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, you understand that the payments may be executed on the next business day.
3. By signing this Agreement, you acknowledge that for ACH debits to your checking/savings account, you understand that because these are electronic transactions, these funds may be withdrawn from your account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF), you understand that TPAX contracted partners responsible for billing you, including through TPAX may, at its sole and absolute discretion, attempt to process the charge again within 15 days. In that case, you agree that TPAX or its contracted partners responsible for billing you, may charge you and to your account an additional $35.00 charge for each attempt returned NSF, which will be initiated as a separate transaction from the authorized recurring payment. You acknowledge that the origination of ACH transactions to your account must comply with the provisions of U.S. law. You certify that you are an authorized user of the credit card/bank account that you have provided us information and will not dispute these scheduled transactions with your bank or credit card company so long as the transactions charged correspond to the terms set forth in this Authorization.
4. You agree to reimburse TPAX, or their contracted partners responsible for billing you, for any claims incurred and or paid during any period of delinquency, including, but not limited to, additional expenses that may be assessed due to late and or non-payment.
5. You agree that you will be automatically billed and provide sufficient and timely credit/debit card or banking information in order for TPAX and/or its contracted partners responsible for billing you in order to effect that process. This include timely notifying TPAX or its contracted partners responsible for billing you in the event your credit/debit card or banking information has changed to ensure there is no payment stoppage, which could impact your continuation of coverage, as further set forth in the Termination & Cancellation Section below.

## Termination & Cancellation

You agree that TPAX and/or LifeX has the right to modify, terminate, or rescind the Initial Coverage or any subsequent Coverage dating back to the original Effective Date if you intentionally provide either LifeX and/or TPAX with inaccurate information, including information about your health or the health of your dependents during the

onboarding process. Rescind means that the coverage was never in effect. Should this Contract be rescinded, you agree to accept liability for all claims that have been incurred by you or your dependents but not paid. Upon cancellation or termination, any claims that have not been incurred before the last day of your coverage will be your sole responsibility as a former Employee, unless the date of service is prior to the cancellation date.

In the event you seek to terminate this Initial Coverage or any subsequent Coverage, you must provide notice to LifeX by email at "admin@lifexresearch.com" using the appropriate form(s) at least fifteen (15) days prior to the requested date of termination ("Minimum Notice"). You understand that any failure to provide this Minimum Notice will result in a termination delay, which will be no less than thirty (30) days. You understand and agree that you remain liable to LifeX for payment of premiums for those experiencing a termination delay.

_____ **Initial** I understand that TPAX will return any contributions that have previously been paid during the ten (10 day) free look period, IF APPLICABLE, minus claims paid.

In the event you fail to pay your deductible, including an event where your credit/debit card or banking information lapses, TPAX and/or LifeX may cancel your Coverage under your Plan. Any cancellation of Coverage under your Plan shall be cancelled retroactively back to the month the last full payment. member shall have a 30-day grace period, after such time, LifeX may cancel Coverage.

## Summary of Benefits & Coverage

The Patient Protection and Affordable Care Act has established new requirements and standards for health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to compare options and select health plans easily. All SBCs can be found by visiting your TPA website and searching "Plans".

## Underwriting Guidelines

Underwriting Guidelines, as established by the Plan, shall be enforced while all Initial and Renewal Contracts are in force and shall continue to do so unless the member is notified otherwise by the Plan.

## Conditions of Plan Coordination

The Plan shall exclude coverage for work-related sickness or injury eligible for benefits under workers' compensation, employers' liability, Own Occupation, Occupational Accident, or similar laws, even when the Covered Participant does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will apply to a Covered Participant who is not required to have coverage under any workers' compensation, personal liability or similar State or Federal law and does not have such coverage. Proof of waiver of coverage will be required for those members eligible who waived or do not enroll based on the State and/or Federal law.

## Terms and Conditions of Plan Participation

These Terms and Conditions set forth, among other things, the nature and requirements of the personal services that you will deliver to LifeX Research Corporation ("Company"), the rights that the Company reserves to assign projects to you, and the employee benefits provided to you as an employee of the Company.

1. **Terms and Conditions of Employee Status.** Your status as an employee is subject to the terms and conditions

set forth herein.

2. **Expectation of Employee Services.** While you are an Employee, you are expected to complete numerous activities per year, timely respond to requests for exchange of health and socioeconomic data information from the Company and remain in regular communication with the Company regarding employment topics issues. The Company reserves the right to assign projects to you at its discretion. You are obligated to notify the Company when you are providing services. You will also be subject to any additional employment policies/terms and conditions as implemented by the Company from time to time, which policies will be published at https://lifexresearch.com/privacy-policy/

3. **Employee Benefits**. While you are an employee, you will be eligible to participate in benefit plans and programs in effect from time to time, including group medical insurance and other benefits as are made available to other similarly situated employees, in accordance with and subject to the eligibility and other provisions of such plans and programs, including, but not limited to, your timely payment of premiums. The Company reserves the right, in its sole discretion, to prospectively modify or terminate any of its benefits plans or programs at any time and for any reason, to the extent permitted by applicable law. To remain enrolled in a benefit plan or program offered by the Company, you may be responsible, pursuant to the terms of the plan or program, to make payment of your share of specified premiums no later than the stated due date for each payment. Failure to pay premiums timely may result in your loss of coverage under the terms of the plan maintained by the Company.

4. **Amendment.** The Company reserves the right, in its sole discretion, to prospectively modify or rescind any of the terms set forth in these Terms and Conditions at any time, to the extent permitted by applicable law.

5. **Severability.** Should any provision of these Terms and Conditions be held by a court of competent jurisdiction to be enforceable only if modified or if any portion of shall be held as unenforceable and thus stricken, such holding shall not affect the validity of the remainder of these Terms and Conditions, the balance of which shall continue to be binding upon the parties with any such modification to become a part hereof and treated as though originally set forth in the Terms and Conditions.

6. **Additional Representations by You.** By accepting these Terms and Conditions, you confirm that you are able to provide services as an employee and carry out the work involved without breaching any legal restrictions on your activities, such as restrictions imposed by a current or former employer. You represent that you have read and understood all of the terms of these Terms and Conditions. You represent that you have had an opportunity to ask questions and consult with an attorney of your choice before signing.

**Employee Signature: Name: Dated:**

## Member Information

Full Name: Address:
Social Security Number: Date of Birth:
Gender: Mobile Number:
Email:
Tobacco User? ☐ Yes ☐ No

Family Status (Choose One)

☐Single ☐ Married ☐ Divorced ☐ Separated

How many total dependents do you have in your household?

What is the age of the oldest person who will be covered under the Plan?

☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+

## Member Attestation & Signature

1. I attest to the truthfulness and accuracy of the information provided in this application.

2. I understand the Plan reserves the right to ask for a current wage & tax statement to verify eligibility when and if applicable.

3. I understand and agree that the Plan may modify health care fees based on risk and/or utilization factors.

4. I understand the Plan reserves the right to ask for acceptance of this Request/Contract by the Plan is subject to my willingness to be bound by the Plan's requirements.

5. LifeX Research Corporation, its successors and assigns, offer a platform designed and underwritten for employees of LifeX. By signing this form, you represent that you are applying for a position of employment at LifeX. Misrepresentation could result in removal from the Plan and denial of claims.

I hereby acknowledge and understand that (1) I must meet all of the Plan's terms and conditions, outlined herein; and (2) absent a Qualifying Life Event, as defined in 26 CFR 1.125-4, participants and any of their respective dependents are not permitted to make changes until the next open enrollment period, as established by the Plan.

I accept full responsibility that the information provided to the Plan regarding myself and any of my respective dependents is accurate. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## Authorization to Obtain Medical Records for Employment Eligibility

**A. PURPOSE OF THIS AUTHORIZATION (Read Carefully)**

LifeX Research Corporation ("LifeX Research") must verify that every Research Associate meets the physical and cognitive ability standards required to perform the essential functions of the job with or without reasonable accommodation (ADA/ADAAA). To do this accurately and fairly, LifeX Research needs to review limited medical records only for the purpose of confirming employment eligibility.
**This is NOT a condition of health-plan enrollment and will not affect your health-plan benefits.**

**B. VOLUNTARY AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**
Initial only if you AGREE to the release described below.

**I AUTHORIZE the following persons/organizations to disclose my PHI to LifeX Research Corporation and third-party providers (Attn: HR Compliance, 2933 West Cyprus Creek Road STE 202, Ft. Lauderdale, FL 33309).**

**_____ Initial**

Any physician, hospital, clinic, pharmacy, laboratory, or other health-care provider that has treated me in the past 5 years.

**Initial**

My health plan(s), pharmacy benefit manager(s), and any third-party administrator.

Description of PHI that will be disclosed regarding medical history, diagnoses, treatment notes, and test results from the past 5 years.

**C. SPECIFIC HIPAA STATEMENTS (Required by 45 CFR § 164.508)**

1. Purpose: Eligibility verification for the Research Associate position.
2. Expiration: This authorization expires 180 days after my date of separation from LifeX Research or upon my written revocation, whichever occurs first.
3. Revocation: I may revoke this authorization at any time by sending written notice to legal@lifexresearch.com (mailto:legal@lifexresearch.com). Revocation will not affect actions already taken in reliance on this authorization.
4. No Conditioning: Signing this authorization is NOT a condition of employment or health-plan enrollment. I understand I may refuse to sign and still be considered for the Research Associate position.
5. Redisclosure: Once LifeX Research receives my PHI, federal privacy law (HIPAA) may no longer protect it from further disclosure by LifeX Research except as required by law.
6. Copy: I have the right to receive a signed copy of this authorization.

**D. APPLICANT CERTIFICATION**

No medical exam is required. This authorization verifies self-reported BFOQ condition only under HIPAA § 164.508, GINA § 1631-2, and ADA § 1630.15(e). Data is not used for health plan enrollment or underwriting.

## AUTHORIZATION AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION OBTAINED FROM HIPAA COVERED ENTITY SOURCES

I, the “Individual” identified on this application, hereby authorize health care providers and other persons or entities with records or knowledge relating to my health, treatment, or pharmacy history to disclose (“**share**”) my information as described in this Authorization and Consent. This includes physicians, hospitals, clinics, laboratories, pharmacies, clearinghouses, pharmacy benefits managers, therapists, rehabilitation providers, health plans and insurers, governmental agencies, and other medically related providers or entities that provide me with care and related services, now or in the

future. These providers and other people or organization that have or know my health information are called "**Sources**").

I agree to these Sources sharing my health and other information contained in my Records (which is defined further below) reasonably needed for purpose of completing a health risk assessment related to insurance coverage and plans for the plan named in the application. This is called "**the Purpose**").

The specific health and other information that may be shared by the Sources under this Authorization and Consent for the Purpose may include my medical records, treatment records, diagnostic testing, pharmacy records, medication lists, problem lists and billing records, sensitive health information (as described in the next paragraph), and other related health reports and records (together, called the "**Records**") that the Sources have about me, now or at the time the Records are shared.

I specifically agree that if any sensitive health information is in my Records, now or in the future, this information can be shared by the Sources with the Recipients (these are defined below) for the Purpose stated above. The Recipients can also share such sensitive health information about me to the fullest extent permitted by applicable laws and for the Purpose listed above.

**I HEREBY EXPRESSLY AUTHORIZE SHARING OF THE FOLLOWING SENSITIVE HEALTH INFORMATION ABOUT ME AS DESCRIBED IN THIS AUTHORIZATION:**

(i) mental and behavioral health records; (ii) substance or alcohol use, treatment or referral for treatment records ("SUD Records"); tuberculosis information; (iii) sexually transmitted disease information, including, but not limited to Human Immunodeficiency Virus/AIDS antigen/antibody test results and related HIV/AIDS information; (iv) reproductive health information (such as birth control use, abortion, pregnancy, or gender related care); and (v) other specially protected health information reasonably necessary for the Purpose described in this Authorization (collected all together, this is called "**Sensitive Health Information."** I understand and agree that Sensitive Health Information does <u>not</u> include genetic information, and this genetic information should not be shared under this Authorization and Consent by the Sources. Sensitive Health Information also does not include Psychotherapy Notes and SUD Counseling Notes that are maintained separately as required by applicable laws, and these Notes also should not be shared under this Authorization and Consent by the Sources. I also understand that, where required by applicable law, additional state-specific language or separate consents may apply.

**I FULLY UNDERSTAND THAT IF I DO NOT WANT MY SENSITIVE HEALTH INFORMATION TO BE SHARED FOR THE PURPOSE AND IN THE WAY DESCRIBED IN THIS AUTHORIZATION, I SHOULD <u>NOT</u> ACCEPT THIS AUTHORIZATION AND CONSENT.**

I agree that the Sources may share my Records with the following persons and entities (each, a "**Recipient**" and all together, the "**Recipients**") **solely** for the Purpose stated above: TPA Exchange Inc,

LifeX Research Corporation and its successors and assigns, TPA Exchange ("TPAX"), KMG Services, Gradient AI, their reinsurers, claims administrators, consumer reporting agencies, other insurance plans, and their authorized agents, employees, representatives, counsel, clinical reviewers, contractors, service providers, and other persons and organizations involved in helping the Recipients to operate their programs and perform the Purpose listed above. I also agree that the Recipients may further share my Records, including Sensitive Information, with the other Recipients for the Purpose described in this Authorization.

I understand that federal and state laws, including HIPAA, apply when certain Sources, like my health care providers, share my Records containing protected health information (PHI) with the Recipients listed above. However, once my Records are shared with the Recipients, HIPAA and other federal and state laws may no longer apply, and the Recipients may further share my Records as permitted by this Authorization and applicable laws. I also understand that certain of my Records that contain substance use disorder (SUD) information ("SUD Records") originating from a qualified SUD Part 2 Program could be protected by the federal drug and alcohol confidentiality law, 42 C.F.R. Part 2 ("Part 2"). I agree that these SUD Records may be shared by the Sources with the Recipients, and may be shared by the Recipients, to the fullest extent permitted by applicable laws and for the Purpose listed in this Authorization. I further understand that:

- If the Recipient is a covered entity (for example, my Medicare Advantage plan) or its business associate who gets this information for treatment, payment or health care operations, my SUD Records may no longer be protected by Part 2 and could be further used and shared by that Recipient in any manner allowed by HIPAA, except civil, criminal, administrative or legislative proceedings against me;
- If the Recipient is a "Part 2 Program" who gets my SUD Records for treatment, payment or health care operations, my SUD Records could be used and shared by that Recipient for these activities and as allowed by Part 2;
- Any other Recipients, for example, life insurance companies, can't share my SUD Records unless allowed by this Authorization or Part 2; and
- SUD Records can never be used in civil, criminal, administrative, and legislative proceedings against me unless I consent separately or by special court order.

I understand that the Recipients may provide payment or other remuneration to the disclosing Sources or their authorized service vendors for collecting, analyzing, maintaining, preparing, transmitting, or otherwise supporting the use or disclosure of my Records for the Purpose described in this Authorization and Consent. To the extent any disclosure is considered a "sale" of protected health information under applicable law, I understand that the disclosure may result in remuneration.

Unless revoked earlier, this Authorization and Consent will remain valid for **twenty-four (24) months** from the date accepted below, or until an earlier expiration is required by law. I understand that I may revoke this Authorization at any time by providing written notice to [med review@tpaexchange.com]

. Any revocation will not apply to Records already shared under this Authorization and Consent before written notice of revocation is received.

I understand that accepting this Authorization and Consent is voluntary and I can refuse to accept it. My treatment, payment, enrollment, or eligibility for health benefits will generally not be conditioned on whether I accept this Authorization and Consent if prohibited by applicable law, however, if I do not accept this Authorization and Consent, my enrollment, eligibility for or benefits determinations in connection with my health plan(s) may be affected.

I may receive a copy of this Authorization and Consent upon request. A photocopy or electronic copy of this Authorization and Consent will be as valid as the original. This Authorization and Consent serves as notice to me of the Recipients who may have access to, use and disclose my Records.

**SIGNATURE OF THE INDIVIDUAL:**

**By entering my initials and signature in the boxes below, I understand that I am accepting and authorizing all of the uses and disclosures of my information as described in this Authorization and Consent.**

**Initials:**

[ ] MY INITIALS HERE MEANS THAT I SPECIFICALLY AGREE THAT THE RECORDS SHARED FOR THE PURPOSE DESCRIBED IN THIS FORM WILL INCLUDE SENSITIVE HEALTH INFORMATION AND MAY BE USED AND DISCLOSED AS DESCRIBED IN THE AUTHORIZATION AND CONSENT UNLESS I REVOKE IT. I UNDERSTAND IF I DO NOT AGREE TO MY SENSITIVE INFORMATION BEING USED AND DISCLOSED IN THIS WAY, I SHOULD NOT SIGN THIS AUTHORIZATION AND CONSENT BELOW.

**Full Signature:**

[ ] MY SIGNATURE HERE MEANS THAT I AM REPRESENTING THAT I AM THE INDIVIDUAL WHO IS NAMED IN THE APPLICATION AND I AM SIGNING THIS AUTHORIZATION AND CONSENT AS OF THE DATE ENTERED ON SUCH APPLICATION I AM SUBMITTING. _____

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**LEGAL NOTICES**

**NOTICE TO RECIPIENTS: 42 CFR part 2 prohibits unauthorized use or disclosure of these records.** These records may contain substance use disorder, mental or behavioral health, HIV/AIDS, reproductive health, or other information subject to special confidentiality protections under federal or state law and may be used or further disclosed only for the purpose(s) authorized by this Authorization or as otherwise permitted or required by applicable law. If genetic information is received under this Authorization, such genetic information **may <u>not</u> be used for underwriting purposes prohibited by HIPAA or state laws**. The Recipient is responsible for complying with all applicable restrictions and must obtain from the individual any additional specific consent or authorization required before using or disclosing the information for any other purpose; a general authorization may not be sufficient, and unauthorized use or disclosure may result in civil or criminal penalties.

**Employee Signature: Name: Dated:**