

# Population Science Management

## Population Science Management Working Owner Application

**Please provide complete and legible information. An incomplete application may affect your consideration for Working Owner status.**

Population Science Management USA, LLC (“Population Science”, “our”, “us” 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 working owner 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 Population Science. Please inform the company’s personnel representative if you need assistance completing this application or to otherwise participate in the application process.

### Job Description: Consumer Data Respondent

The Consumer Data Respondent (CDR) provides data insights through questionnaires on topics that PSM deems important in understanding consumer behavior related to healthcare services utilization. This role is also called upon to provide general consumer insights that better inform service consumption and predictive modeling. This position requires you attest to the truthfulness and accuracy of all information provided to the Employer during the employment relationship, including this Employment Application in any other documents. You will be required to accurately, truthfully, and timely complete surveys at various times throughout the year at your discretion. Your responses are valuable to Population Science.

Applicant certifies you are not applying on behalf any other individuals other than those who are considered dependents.

## Health Plan Enrollment

### Introduction

Population Science Management USA LLC, including its successors or assigns (“Population Science”, “PSM”, “our”, “us” or “we”) is proud to offer you a number of available health plans (the “Plans”) to choose from as a Working Owner of

Population Science Management. The health and wellness benefits offered by Population Science are based on a managed care model (the “Program”).

## **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 Population Science via this application process or at any point during your term as a Working Owner, you hereby authorize to use and/or disclose the protected health information about you described below (“PHI”) to the medical providers and partners of Population Science associated to you based on caretaker status to the you, health care provider, specific medication, insurance 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 in order to provide a health care benefit. The 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 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. I understand that any information that I provide to Population Science 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.
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 a working owner of Population Science, 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@populationsciencemanagement.com](mailto:legal@populationsciencemanagement.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 Population Management’s initiatives aimed at improving the health and wellbeing of the Program .
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.

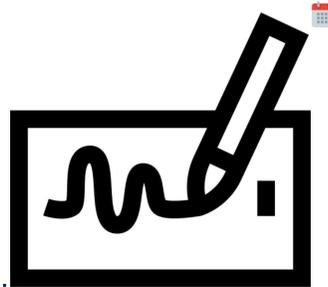
**By checking off, you agree to the terms of this Authorization.**

## **Applicant Representations and Warranties**

Please read all 7 items below carefully as you will be required to check off each one and attest to your understanding and agreement to all of them.

- I read and understand that this plan excludes specialty medications.
- I understand that Population Science will return any contributions that have previously been paid as to ANY the rescinded coverage, IF APPLICABLE, minus claims paid.
- I understand that the information contained in this Application is for information purposes only and does not guarantee or bind Population Science to provide health benefits coverage.
- I consent to being contacted with certain non-emergency, automated, pre-recorded or other text message communications from PSM and its partners under the Telephone Consumer Protection Act (TCPA). By checking off, you authorize us and our affiliates to contact you using the phone number listed on this Application.
- I understand that PSM gathers this information for statistical and actuarial uses only and it will not be used in connection with decisions or actions regarding employment.
- That as a prospective member, I have the right to request restrictions on how my protected health information is used, and that PSM is not required by law to grant this request, but if the request is granted, PSM is bound by this agreement. I also understand that I have the right to revoke this consent in writing, except to the extent PSM has already used or disclosed the protected health information in reliance upon my consent. I further understand that PSM 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 is admitted as a Working Owner of Population Science, its successors and assigns, subject to payment of a capital contribution, which will be invoiced to me.
- 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 Population Science may rescind healthcare coverage and deny or terminate working owner ownership.

**By agreeing above and signing below, you certify under penalty and perjury of law that the foregoing representation and warranties are true and accurate.**



**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

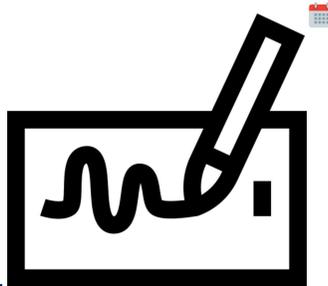
drugs are often **biologics**—“drugs derived from living cells” that are injectable or infused (although some are oral medications).

Due to this exclusion, the plans work with a 3<sup>rd</sup> party vendor that can source medication through foundational assistance (ie. “PAP”) based on qualifying set of criteria including income and household size.

For those medications that are on this formulary, Population Science 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.

**PLEASE NOTE:** FOR PLANS THAT HAVE MyLiveDoc as their Pharmacy, these Plans include only a limited number of acute generic medications including approximately 70 in acute care medications. All chronic medications are mail-order. 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 Population Science 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 Population Science 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, will 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. 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

### **Rates & Contract Terms**

Once a Member also referred to as a Working Owner is entered into a plan of their choice (the “Plan”), the initial term of that Plan (the “Initial Contract”) shall remain in force under one of three possible Deductible Years, as follows:

**Option 1 Calendar Year Deductible (GigCare):** If a Member chooses a Plan with a fixed **Calendar Deductible Year**, the initial term will end on the first December 31<sup>st</sup> following the initial enrollment month (Effective Date). The deductible will reset on the next January 1<sup>st</sup> 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 1<sup>st</sup>.

**Option 2 Non-Calendar Year Deductible (RBP/PPO):** If a Member chooses a Plan that has a **Non-Calendar Deductible Year**, the initial term will begin on the enrollment month (Effective Date) and run for 12 months. The deductible will reset on the first day of the month following the completion of the initial 12-month term. For example, if a Member enrolls in September, their deductible will run until September 30 of the next year and reset on October 1 of the following year.

**Option 3 Anniversary Date Deductible (TDK):** If a Member chooses a Plan that has an Anniversary Date Deductible Year, the initial term will begin on the enrollment day (Effective Date) and run for 12 months. For example, if a Member enrolls on August 21, 2024, their deductible will run until August 20, 2025 and renew on August 21, 2025.

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

- Calendar Deductible Year plans will reset on the first of January following the completion of 12 months on the plan.
- Non-Calendar Deductible Year plans will reset at the end of 12 months following their Effective Date.

Working Owners 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. 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 Population Science Management, including its successors and assigns, payments for coverage under anyone 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 (see Options (1) – (3) 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 PSM. Payment of money to cover the cost of the Plan shall be remitted to PSM monthly, subject to the following guidelines for Billing and Collections:

1. By signing this Application, you authorize Detego Health LLC (“Detego Health”) (shown on your credit card as DTGOHLTH) or any of its contracted partners to:
  - a. For initial coverage, immediately charge your credit card or auto-debit your checking or savings account as indicated on your quote, and
  - b. For recurring payments, on or around the 20th 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 PSM 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 PSM or its contracted partners responsible for billing you, including through Detego Health may, at its sole and absolute discretion, attempt to process the charge again within 15 days. In that case, you agree that PSM including through Detego Health 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 PSM or its 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 PSM and/or its contracted partners responsible for billing you in order to effect that process. This include timely notifying PSM 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 PSM 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 PSM with inaccurate information, including information about your health or the health of your dependents during the underwriting 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 received by PSM before the cancellation will be your sole responsibility as a former Member, 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 PSM by email "MemberServices@detegohealth.com" using the appropriate form(s) at least fifteen (15) days ("Minimum Notice") prior to the requested date of termination. 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 to remain liable to PSM for payment of premium for those experiencing a termination delay.

In the event you fail to pay your deductible, including an event where your credit/debit card or banking information lapses, PSM 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, PSM may cancel Coverage.

## **Summary of Benefits & Coverage**

The Patient Protection and Affordable Care Act has established many 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/Working Owner 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.

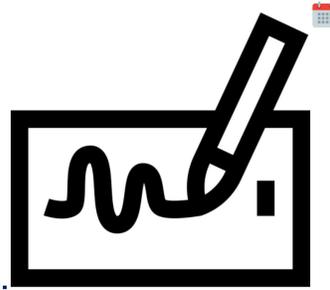
## Terms and Conditions of Plan Participation

Pursuant to the Limited Liability Company Agreement of Population Science Management USA (“LLC Agreement”) subsidiary, you will be admitted as a Working Owner under Section 5.01(c) of the LLC Agreement, subject to your agreement to these Working Owner Personal Services Terms and Conditions (“Terms and Conditions”). These Terms and Conditions set forth, among other things, the nature and requirements of the personal services that you will deliver to Population Science Management USA (“Company”), the rights that the Company reserves to assign projects to you, and the employee benefits provided to you as a Working Owner of the Company.

- 1. Terms and Conditions of Working Owner Status.** Your status as a Working Owner is subject to the terms and conditions set forth herein.
- 2. Expectation of Working Owner Services.** While you are a Working Owner, 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 Working Owner 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 Working Owner services. You will also be subject to any additional Working Owner policies as implemented by the Company from time to time. Failure to comply with these terms may result in the Company invoking its Call Right, as described below.
- 3. Guaranteed Payment.** For each response to an information request, the Company shall pay you a “Guaranteed Payment,” as that term is used in Code Section 707(c).
- 4. Grant of Preferred Units.** Pursuant to Section 5.01 of the LLC Agreement you have been granted three (3) Preferred Units in the Company. You understand and agree that the Preferred Units are being transferred to you in compensation for your performance of personal services in a transaction not involving any public offering in the United States within the meaning of the Securities Act of 1933, as amended (the “Securities Act”) and that the Preferred Units will not be registered under the Securities Act or any state or foreign securities or “blue sky” laws and that it is anticipated that there will be no public market for the Preferred Units. You understand and agree that the Company is under no obligation to file any registration statement with the Securities and Exchange Commission

in order to permit transfers of the Preferred Units. You are acquiring the Preferred Units for your own account for investment purposes and not with a view to, or for offer or sale on behalf of yourself or the Company in connection with, the distribution or resale thereof. As appropriate, these Terms and Conditions are intended to comply with Rule 701 of the Securities Act and its applicable regulations and shall be interpreted consistently therewith.

5. **Working Owner Benefits.** While you are a Working Owner 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 Working Owners, 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 and/or permit the Company to invoke its Call Right, as described below.
  
6. **Confidentiality.** You confirm that you have read and understand the provisions of Section 14.03 of the LLC Agreement with respect to Confidential Information, and further agree that you will not remove or copy any documents, proprietary data, or similar materials of any kind, electronic or otherwise, obtained in your position as a Working Owner, nor will you disclose any Confidential Information during the course and scope of your services as a Working Owner with the Company.
  
7. **Call Right.** As specified in Section 5.04 of the LLC Agreement, should a Working Owner not meet these conditions of Working Owner status as specified in these Terms and Conditions and in the LLC Agreement, the Company shall reserve its Call Right to cause the Working Owner to sell all of their Membership Interest to the Company pursuant to the process described in Section 5.04 of the LLC Agreement.
  
8. **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.
  
9. **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.
  
10. **Additional Representations by You.** By accepting these Terms and Conditions, you confirm that you are able to provide services as a Working Owner 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 and the LLC Agreement. You represent that you have had an opportunity to ask questions and consult with an attorney of your choice before signing.



**Working Owner Signature & Dated:**

**Name:\$fullname**

## **Joinder Agreement**

The following **Joinder Agreement** allows this member and dependents access to the ERISA health plan offered by a subsidiary of Population Science Management USA. It is important that you as a Member understand in plain language, what membership entails:

1. As a Preferred Unit holder, the signatory to the Joinder Agreement **does not** expose the Member to any financial or legal liability, outside of the obligation to make contributions as specified herein, and obligations otherwise provided in the LLC Agreement.
2. As a Preferred Unit holder in accordance with the LLC Agreement, the Member is required to participate in above mentioned activities for which they will be paid with funds placed on a debit/credit card.
3. Member understands and consents to the use of their de-identified data for research purposes.

Reference is hereby made to the Limited Liability Company Agreement, as amended from time to time (the "LLC Agreement"), among the existing Members of a subsidiary of Population Science Management USA, (the "Company"). Pursuant to and in accordance with Section 5.01(b) of the LLC Agreement, the undersigned hereby acknowledges that:

I, the person named and signing below, has joined the LLC Agreement as a limited member, and:

1. Acknowledge I have received and reviewed the LLC Agreement with the opportunity and encouragement to seek the advice and consultation of independent and tax counsel;
2. Acknowledge and confirm my joinder of the LLC Agreement as a limited member with the internal in the Company equal to the value of the limited membership given to me;
3. Acknowledge and confirm that I will be required to make capital contributions in the amount specified by the Company or its delegate, subject to the terms of the LLC Agreement; and
4. Acknowledge that this Joinder Agreement and my ownership interests in the Company will be subject to the restrictions against transfer stated in the Joinder Agreement and the following restriction:

THE MEMBERSHIP INTERESTS HAVE NOT, NOR WILL BE, REGISTERED OR QUALIFIED UNDER FEDERAL OR STATE SECURITIES LAWS. THE MEMBERSHIP INTERESTS MAY NOT BE OFFERED FOR SALE, SOLD, PLEDGED, OR OTHERWISE TRANSFERRED UNLESS REGISTERED OR QUALIFIED, OR UNLESS AN EXEMPTION FROM REGISTRATION OR QUALIFICATION EXISTS. THE AVAILABILITY OF ANY EXEMPTION FROM REGISTRATION OR QUALIFICATION MUST BE ESTABLISHED BY AN OPINION OF COUNSEL FOR THE OWNER, WHICH OPINION AND COUNSEL MUST BE REASONABLY SATISFACTORY TO THE MEMBERSHIP.

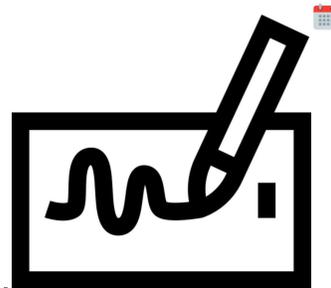
5. Agree to be bound by the terms and conditions of the LLC Agreement and Joinder Agreement.

6. Acknowledge that the following disclosures have been made before my execution of this Joinder Agreement:

THE UNITS OF THE MEMBERSHIP HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT"), OR THE SECURITIES LAWS OF ANY STATE. THE UNITS OF THE MEMBERSHIP ARE OFFERED AND SOLD IN RELIANCE ON EXCEPTIONS FROM THE REGISTRATION REQUIREMENT OF THE SECURITIES ACT AND SUCH LAWS, AND PARTICULARLY REGULATION D. THE MEMBERSHIP WILL NOT BE SUBJECT TO THE REPORTING REQUIREMENTS OF THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED, AND WILL NOT FILE REPORTS, PROXY STATEMENTS AND OTHER INFORMATION WITH THE SECURITIES AND EXCHANGE COMMISSION.

6. I have received and reviewed a complete copy of the LLC Agreement and agree that upon execution of this Joinder Agreement, I shall become a party to the LLC Agreement and shall be fully bound by, and subject to all the covenants, terms, and conditions of the LLC Agreement as though an original party thereto and shall be deemed, and is hereby admitted as, a Member for all purposes thereof and entitled to all the rights incidental thereto and shall hold the status of Participating member.

*Capitalized terms used herein without definition shall have the meanings ascribed thereto in the LLC Agreement.*



**Working Owner Signature & Dated:**

**Name:\$fullname**

## **Spousal Consent**

I, , spouse of \$fullname, acknowledge that I have been given access to read the Operating Agreement ("the Agreement"), dated May 19th, 2023 by a subsidiary of Population Science Management USA (the "Company"), to which this Spousal Consent (this "Consent") is attached (as the same may be amended or amended and restated from time to time, the "Agreement"), and that I understand the contents of the Agreement. I am aware that my spouse is a party to the Agreement and the Agreement contains provisions regarding the voting and transfer of the Membership Interests (as defined in the Agreement) of the Company, which my spouse may own, including any interest I might have therein.

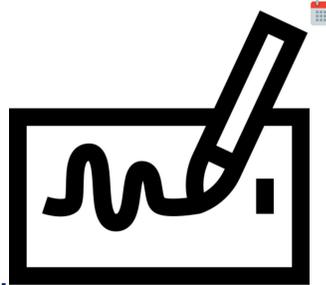
I hereby agree that I and any interest, including any community property interest, that I may have in any Membership Interests of the Company subject to the Agreement shall be irrevocably bound by the Agreement, including any restrictions on the transfer or other disposition of any Membership Interests, valuation methods, or agreed values for the Membership Interests or voting or other obligations as set forth in the Agreement. I hereby irrevocably appoint my spouse as my attorney-in-fact with respect to the exercise of any rights and obligations under the Agreement. I agree that, in the event of divorce or the dissolution of my marriage to my present spouse or other legal division of property, I will transfer and sell, at the fair market value, to my spouse any and all interest I have or may acquire in the Company, and I further agree that a court may award such entire interest to my spouse as part of any such legal division of property. The foregoing agreement is not intended as a waiver of any community property or other ownership interest I may have in the Membership Interests of the Company, but only as an agreement to accept other property or assets of substantially equivalent value as part of any property settlement agreement or other legal division of property upon divorce or the dissolution of my marriage. I agree not to bequeath my interest, if any, in the Membership Interests of the Company, by will, trust, or any other testamentary disposition to any person other than my current spouse. Further, the residuary clause in my will shall not

include my interest, if any, in the Membership Interests of the Company. I agree not to pledge or encumber any interest I may have in the Membership Interests of Company.

This Consent shall be binding on my executors, administrators, heirs, and assigns. I agree to execute and deliver such documents as may be necessary to carry out the intent of the Agreement and this Consent. I am aware that the legal, financial, and related matters contained in the Agreement are complex and that I am free to seek independent professional guidance or counsel with respect to this Consent. I have either sought such guidance or counsel or determined after reviewing the Agreement carefully that I will waive such right. I am under no disability or impairment that affects my decision to sign this Consent and I knowingly and voluntarily intend to be legally bound by this Consent. I am satisfied with the terms of this Consent and I understand and have received full disclosure of all the rights that I am agreeing to waive.

I hereby agree that my spouse may join in any future amendment, waiver, consent, or modification of the Agreement without any further signature, acknowledgment, agreement, or consent on my part or notice to me.

**Spouse Name:\$spouse\_dependent**



**Spouse Signature: Date:**

**Spouse Email:**

I understand for my policy to remain in effect, assuming my spouse is enrolled that my spouse is required to sign the spousal consent with this Joinder Agreement.

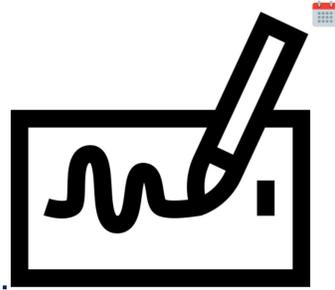
## **Member Attestation & Signature**

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. PSM , its successors and assigns, offer a platform designed and underwritten for self-employed individuals. By signing this form, you represent that you are self-employed. You further represent that you can provide proof of being self-employed. Population Science, its successors and assigns reserves the right to request evidence from any member while participating in the health plan. 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.



**Working Owner Signature & Dated:**

**Name:\$fullname**