

# Large Group Employer Application



MASSACHUSETTS

## PRODUCT (Check the appropriate box)

<input type="checkbox"/> HMO <input type="checkbox"/> Premium <input type="checkbox"/> Value <input type="checkbox"/> Choice Copay Option <input type="checkbox"/> Basic <input type="checkbox"/> Advantage	<input type="checkbox"/> Option (Complete sections 1, 2, 5 and 6) <input type="checkbox"/> Total Replacement (Complete all sections) <input type="checkbox"/> Joint Offering HMO/HMO (Complete all sections) <input type="checkbox"/> Dual Option (Complete all sections)
<input type="checkbox"/> POS <input type="checkbox"/> Premium <input type="checkbox"/> Value <input type="checkbox"/> Basic <input type="checkbox"/> Choice Copay Option (available 10/1/06)	<input type="checkbox"/> Total Replacement (Complete all sections) <input type="checkbox"/> Dual Option (Complete all sections)
<input type="checkbox"/> PPO <input type="checkbox"/> Premium <input type="checkbox"/> Value <input type="checkbox"/> Basic <input type="checkbox"/> Advantage Option <input type="checkbox"/> Navigator by Tufts Health Plan <input type="checkbox"/> Carelink	<input type="checkbox"/> Total Replacement (Complete all sections) <input type="checkbox"/> Dual Option (Complete all sections)
<b>Consumer-Driven Health Care</b>	<input type="checkbox"/> Liberty by Tufts Health Plan, powered by Destiny Health

## 1) GENERAL INFORMATION (please type or print legibly)

Full legal name of employer \_\_\_\_\_

Address \_\_\_\_\_

Phone # (        ) \_\_\_\_\_ Fax # (        ) \_\_\_\_\_

Enrollment contact name \_\_\_\_\_ Billing contact name \_\_\_\_\_

Nature of business and SIC code \_\_\_\_\_

Date business established \_\_\_\_\_ Tax I.D. number \_\_\_\_\_

Email address \_\_\_\_\_ Web site \_\_\_\_\_

Is the Group a         Corporation         Partnership         Sole Proprietorship         Other

If other, please specify \_\_\_\_\_

Subsidiaries or affiliates to be covered and locations \_\_\_\_\_

Total number of employees employed        Full-Time \_\_\_\_\_ Part-Time \_\_\_\_\_

How many were employed 12 months ago? \_\_\_\_\_



## 4) CONFIRMATION OF INFORMATION

- If the employees contribute toward the cost of the insurance, at least 75% of the eligible employees must be enrolled in a group sponsored plan on the effective date.
- The Employer may cancel coverage upon 30 days written notice to Tufts Health Plan, prior to any monthly premium due date.
- State requirements may alter various provisions of an employer's plan.
- Tufts Health Plan may cancel coverage for the Group's non-payment of premium, failure to meet contribution or participation requirements, fraud or misrepresentation; if all of the Group's employees move outside the Tufts Health Plan service area; or if Tufts Health Plan ceases to offer the particular product the Group purchases or ceases to offer coverage in the market.
- Tufts Health Plan may change premiums and benefits on contract renewal date or when otherwise required or permitted by law or regulation.

## 5) REPORT OF BROKER OF RECORD

Any commissions that may become payable as a result of soliciting this request will be payable only to the broker or brokers designated by the applicant below. If more than one broker is so designated, commissions will be payable in equal shares.

### BROKER DESIGNATION

The Group designates \_\_\_\_\_ as broker of record. The Group agrees to notify Tufts Health Plan, in writing, if it wishes to designate a different broker of record.

The Group acknowledges the broker of record will be eligible to receive either Tufts Health Plan's standard monthly commission (available upon request), or \_\_\_\_\_. The Group also acknowledges broker may receive additional compensation, such as annual bonuses (new business, persistency and/or retention bonuses), as well as other items awarded to broker of record that may be attributable to the sale and/or retention of the Group.

Make commissions payable to \_\_\_\_\_

On the basis of the knowledge I have regarding the financial, health and other insurance risk elements of the Employer and its employees and their dependents, I recommend this firm for participation in this plan for which application is being made.

Broker Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

License # \_\_\_\_\_ Broker Tax ID # \_\_\_\_\_

## 6) GROUP REPRESENTATION AND WARRANTY

The Group represents and warrants that coverage will become effective only upon Tufts Health Plan's acceptance of this application and payment of the required premium or fee at rates Tufts Health Plan determines. If approved, the effective date of coverage will be (a) the effective date mutually agreed upon between Tufts Health Plan and the employer or (b) the date the required number of employees who are to contribute to the cost of the coverage have enrolled, whichever is later. The Group represents and warrants that, to the best of its knowledge, the information contained in this application is complete and true.

Signed at (city & state) \_\_\_\_\_

Name of applicant/employer \_\_\_\_\_

Date signed \_\_\_\_\_ By (signature/title) \_\_\_\_\_