

Small Group Employer Application

MASSACHUSETTS

1) GROUP INFORMATION

Full legal name of group _____ (the "Group")

Corporate headquarters address _____

City _____ State _____ Zip _____

Contact name _____ Title _____

Mailing address (if different) _____

Billing address (if different) _____

Billing contact name (if different) _____ Title _____

Phone # () _____ Fax # () _____

Email address _____ Web site _____

Nature of business _____ SIC code _____ D-U-N-S[®] # (9 digit) _____

Date business established _____ Tax I.D. number _____

Is the Group a Corporation Partnership Sole Proprietorship LLC Other

If other, please specify _____

Is the Group a subsidiary or branch of a corporate parent? Yes No

If yes, what is the total number of employees in all subsidiaries and branches of the corporate parent? _____

List the name and location of the corporate parent and any other subsidiaries and branches of the corporate parent:

Is the Group eligible to file a combined state tax return with another legal entity? Yes No

If yes, what is the total number of employees in all entities that are eligible to file a joint state tax return? _____

List the name and location of all other legal entities with which the Group is eligible to file a combined state tax

return: _____

Are there office locations other than the one listed above? Yes No

If yes, what are they? _____

Number of full time employees _____ Number of part time employees _____

Number of seasonal employees _____ How many were employed 12 months ago? _____

How many employees are eligible for health insurance? _____

2) BROKER DESIGNATION, IF APPLICABLE

Brokerage/Agency _____ is the Group's designated broker of record. The Group agrees to notify Tufts Health Plan, in writing, if it wishes to designate a different broker of record.

Broker phone number _____ Broker fax number _____

Broker Email address _____

Make commissions payable to _____

Broker Tax I.D. Number _____ Signature _____

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.

3) HEALTH PLAN INFORMATION

- Choose one**
 HMO
 Premium
 Value
 Basic
 Choice Copay Option

 Advantage
 Saver
 Select Network

 PPO
 Premium
 Value
 Basic

 Advantage
 Saver

 POS
 Premium
 Value
 Basic
 Choice Copay Option

Requested effective date of coverage for the Group _____
 (Future anniversaries will be set on the 1st or 15th of the month)

Eligibility: Active, full time employees (working 20-hrs. minimum).*
 Employees covered under a collective bargaining agreement are
 Included Excluded Not Applicable
 Other eligibility requirements _____

* At least one active employee must work no fewer than 30 hours per week.

The Group's waiting period, if any
 None
 1 month
 2 months
 3 months*
 4 months*
 5 months*
 6 months*
 The effective date of coverage for new eligible employees is
 The date of hire
 The 1st of the month following satisfaction of waiting period
 The day the waiting period has been satisfied (i.e. one month from date of hire)
 On the original effective date do you wish to waive the waiting period for all eligible employees?
 Yes No

*You may have obligations under MA HealthCare Reform Act. Please review with your counsel. (See 956 CMR 4.07 (3)(b)).

Does the Group have an existing health plan(s)? Yes No
 If yes, current carrier(s) _____ Renewal Date _____
 Reason for transfer _____
 Number of employees covered under the Group's current plan _____
 Number of employees declining coverage due to coverage under another health plan not sponsored by this employer _____

<input checked="" type="checkbox"/> Monthly premium of existing carrier		Employer Contribution (%)
Employee	\$ _____	_____
Employee/Spouse	\$ _____	_____
Employee/Child	\$ _____	_____
Employee/Children	\$ _____	_____
Family	\$ _____	_____

NOTE: Tufts Health Plan requires minimum of 50% employer contribution toward individual coverage, 33% toward couple, employee/child and family monthly premiums.

HEALTH PLAN INFORMATION (cont'd)

■ Will the Group also offer coverage through another group health plan? Yes No

If yes, name and renewal date of other carrier(s) _____

■ Are any former employees or dependents continuing coverage under a provision of COBRA or any state continuation of coverage? Yes No If yes, please list each person below

Name	Type of Continuation	Reason for Continuation	Start Date of Continuation	End Date of Continuation

■ A credit report such as Dunn & Bradstreet may be requested. Are there any pending or anticipated events that might affect the financial condition or composition of the Group (for example, credit rating or group size)?

Yes No

■ Has the Group ever offered Tufts Health Plan before? Yes No If yes, from _____ to _____

Reason for leaving Tufts Health Plan? _____

Was the Group covered under a different legal name other than what is listed in Section 1?

Yes No If yes, please indicate the legal name _____

4) CONFIRMATION OF INFORMATION

By submitting this application, it is understood and agreed that

■ Participation in Tufts Health Plan will not be effective until Tufts Health Plan provides written notification including rates and the effective date of your coverage.

■ For HMO plans, if any members of the Group are hospitalized on the effective date, benefits for such member begin when Tufts Health Plan is notified and given the opportunity to manage the member's medical care.

■ Tufts Health Plan may request a copy of last year's tax return or, if your company has been in business for less than one year, your tax identification number, to be followed by a copy of your first quarterly tax return. Tufts Health Plan may also request the following information

1) A complete and current census including the name, date of birth, family status and zip code of each eligible employee: and updated COBRA/Continuation of Coverage information.

2) A completed Waiver Form for all eligible employees who are waiving their right to group health care coverage.

■ In order to be accepted for coverage, the Group must

1) Meet Tufts Health Plan's participation requirements;

2) Contribute at least 50% toward the individual and 33% toward the couple/family, employee/child or employee/children premiums; and

3) Accept the Tufts Health Plan Employer Group Agreement.

5) REPRESENTATION AND WARRANTY

By signing below, I represent, warrant and agree that:

■ Pursuant to Massachusetts Law the Group must meet all requirements to be considered an eligible small business, including, but not limited to

- The Group must be actively engaged in business;
- The Group must employ not more than 50 eligible employees, the majority of whom work in Massachusetts; and
- The Group must employ at least one full-time eligible employee who works a minimum of 30 hours per week.

■ The Group is not a subsidiary, affiliate or branch of any other corporation.

■ Within the last 12 months the Group has not

- Made more than three late payments to its insurance carrier(s), if any;
- Committed fraud, misrepresented the eligibility of an employee, or misrepresented information necessary for a carrier to determine Group size, Group participation or the Group premium rate,
or
- Failed to comply in a material manner with a health benefit plan provision, including carrier requirements for employer group premium contributions.

■ With the exception of COBRA or Continuation of Coverage participants, all subscribers who enroll for coverage under Tufts Health Plan satisfy the following requirements

- They are considered regular, full-time employees compensated for working at least 20 hours per week for the group;
- They receive an annual W-2 Form and;
- They are hired to work for a period of not less than five months.

■ The information contained in this application is complete and true.

The Group acknowledges that its coverage will become effective only upon Tufts Health Plan's written acceptance of this application and payment by Group of the required premium at rates determined by Tufts Health Plan. The Group also acknowledges that if the Group commits fraud or misrepresents matters related to this application, Tufts Health Plan has the authority to retroactively terminate coverage back to the date of the fraud or misrepresentation. If Tufts Health Plan accepts this application, the Employer Group Agreement will become effective on the latter of the effective dates requested or on the date the required number of employees have enrolled, whichever is later.

Signature _____

By (print) _____

Title (print) _____

Date _____