Group Application Form

Thank you for choosing Neighborhood Health Plan. Please complete the requested information in Parts One, Two, and Three. Part Four will be completed by Neighborhood Health Plan. Please read Parts Five and Six, sign this completed application form, and return it to your NHP Sales Account Executive prior to enrollment.

Part One – Group Information

1. Employer's Legal Name______________________________

Employer's Business Address
(Street, City, State, Zip Code)______________________________

Executive Contact

Name____________________ Title____________________

Phone Number____________ Email____________ Fax Number____________

Billing Contact

Name____________________ Title____________________

Phone Number____________ Email____________ Fax Number____________

Billing Address
(Street, City, State, Zip Code)______________________________
Or indicate same as Business Address above ☐

Nature of Business______________________________

Standard Industry Classification (SIC) or NAICS (if known)____________________

Employer's Tax ID Number______________________________

Employer Web Site______________________________

Does Employment Vary Seasonally? ☐ Yes ☐ No If Yes, Explain Below

____

2. Information about any **subsidiaries or affiliates** that are a separate legal entity and whose employees are to be included. Give subsidiary's legal name and business address (Street, city, State, Zip Code) below. Please copy this page if necessary to include additional affiliates.

Subsidiary Name______________________________

Subsidiary Business Address
(Street, City, State, Zip Code)______________________________

Employer's Tax ID Number______________________________

Nature of Business______________________________

Does employment vary seasonally? ☐ Yes ☐ No If Yes, explain below

____

Part Two – Group Enrollment Information

1. Eligible employee is defined as permanent full-time regularly working 30 or more hours per week and permanent part-time employees working at least 20 hours per week, the majority whom work in Massachusetts.

A. Do you plan on enrolling employees other than those described above? ☐ Yes ☐ No If Yes, Explain Below:

____

B. Do you exclude employees from coverage? ☐ Yes ☐ No If Yes, explain below:

____

2.

A. What is the total number of your permanent employees that are actively working and eligible for health care coverage? ____________________

B. Of the employees described in A, what is the total number that you have not enrolled because they are enrolled in another group health plan through their spouses or because they have voluntarily waived coverage? ____________________
(Health Coverage Waiver Forms for each employee identified in B. must accompany this application)

C. What is the total number of other personnel who are not actively working but are eligible for your group health care coverage (For example, Retirees, COBRA)? ____________________

3. What is the probationary time period (waiting period) in months for employees before they become eligible for health coverage?

Full-Time Employees____________________ Part-Time Employees__________________

Part Three – Other Insurance Information

A. Workers Compensation Carrier

Carrier Name____

Phone Number_______________________________________ Policy Effective Date______________________

B. Other Health Insurance Carriers:

Name/Anniversary date	Monthly Premiums	Copayments			Deductible (list amount or "none")	Group Type (see below)	Number of Enrollees	Employer's Contribution: Indicate Percent or Fixed Amount (if other method, please explain below) ☐ Percent ☐ Fixed amount		
		Office	ER	Rx				Individual	Family	Other*

*Other:____

Group Type Codes: 1-Regular
2-COBRA
3-Retiree Under 65
4-Other

Part Four – Benefit Information (to be completed by Neighborhood Health Plan)

SIC Code________________ Rate Effective Date: Month______________ Day_____ Year________

☐ New Business (no current NHP health plan)

☐ New Group (adding group to existing NHP account)

List New group and existing group information below.

Group Number	Requested Effective Date	Product	Group Type (see below)	Number of Enrollees	Employer's Contribution: Indicate Percent or Fixed Amount (if other method, please explain below) ☐ Percent ☐ Fixed amount		
					Individual	Family	Other*

*Other:____

Group Type Codes: 1-Regular
2-COBRA
3-Retiree Under 65
4-Other

Part Five – Broker Designation

I hereby authorize________________ of ______________________ to obtain and receive information from
Name of individual broker *Name of agency with whom broker is affiliated, if applicable*

Neighborhood Health Plan on______________________'s behalf and to receive fee and/or commission compensation on
Account name

the group health insurance plan(s) established by this group application. This designation is effective______________ and will remain
Effective date

in effect until rescinded in writing by me or an authorized representative of__________________________.
Account name

I certify that I have contract signing authority to designate broker payment.

Name____________________ Title________________________ Date__________

Part Six – I Understand That . . .

1. Coverage is not effective until approved by Neighborhood Health Plan.
2. Requested effective date of coverage may be declined or deferred if the information submitted is incomplete.
3. Existing coverage should not be canceled until this request is approved.
4. No broker or consultant may make or modify a contract from Neighborhood Health Plan.
5. Final premium rates are subject to current Neighborhood Health Plan underwriting guidelines and final enrollment.
6. All enrolled groups are subject to enrollment eligibility review at any time.
7. All groups must verify their enrollment on an annual basis at renewal.
8. Groups found to have misrepresented eligibility of subscriber(s) are subject to immediate cancellation, with no conversion privileges, and are liable for all benefits paid for inappropriate enrolled subscribers.
9. NHP has elected to meet the ACA requirement for the provision of pediatric dental coverage services through a stand-alone dental plan that has been certified by the Commonwealth Health Insurance Connector Authority as a Dental Qualified Health Plan (DQHP), rather than through embedding coverage. As such, Group acknowledges that NHP's health insurance plans do not include pediatric dental coverage and it is the Group's responsibility to verify that each of the Group Subscribers and Subscribers' dependents are enrolled in Dental Qualified Health Plan coverage. Upon request, Group agrees to provide NHP with documentation necessary to verify that each employee and dependent covered under this Health Plan is also covered by a DQHP. Group acknowledges that any failure to provide requested documentation to NHP, any termination of the Dental Plan, or any misrepresentation in this Attestation may lead to termination of the group Health Plan coverage by NHP retroactive to the effective date of enrollment.

I certify that the information in this application is true and complete

Signed By (Authorized Employer Representative)______________________________ Date______________

Print Name________________________ Title________________________

Employer Group____

Broker Signature______________________________ Date______________

Broker Agency____