MASSACHUSETTS
SMALL GROUP EMPLOYER APPLICATION

TUFTS Health Plan

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; or 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 locations (being either subsidiaries or branches of the corporate parent; or entities eligible to file a joint state tax return)?_____

List the name and location of all locations (being either subsidiaries or branches of the corporate parent; or entities eligible to file a joint state tax return):

_____

The information below is required for Medicare Secondary Payor (MSP) reporting:

The total number of current employees who receive wages, tips, or other compensation (refer to line 1 of your most recent federal tax return form 941 or 944 _____ (includes FT, PT, seasonal, new hire): as of this date_____ (mm/dd/yy).

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.

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3. HEALTH PLAN INFORMATION

Please provide plan selected: ❑ HMO ❑ PPO
Plan name:_____

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 _____
* The group must employ at least one full-time eligible employee who works a minumum of 30 hours per week.

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?** _____

Group elects coverage for Domestic Partnerships (required for both same sex and opposite sex domestic partners)

❑ Yes ❑ No

Groups offering domestic partnership coverage agree that coverage is extended to both same sex and opposite sex domestic partners. Group agrees that it is responsible for collecting and maintaining the Domestic Partner Affidavits (form is available through Tufts Health Plan). Group is responsible for verifying the eligibility of each domestic partner, as stated in the Tufts Health Plan Domestic Partners Policy. Upon request, Group will provide Tufts Health Plan with documentation verifying domestic partner eligibility.

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 _____

Employer Contribution (%)
EE_____% EE/SP_____% EE/CH_____% EE/CH(ren)_____% Family_____%

NOTE: Tufts Health Plan requires minimum of 50% employer contribution toward individual coverage, 33% toward EE/SP, EE/CH, EE/CH(ren) and family monthly premiums.

Monthly premium of existing carrier
EE $_____ EE/SP $_____ EE/CH $_____ EE/CH(ren) $_____ Family $_____

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3. HEALTH PLAN INFORMATION (continued)

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, employee/children or family premiums; and

    3) Accept the Tufts Health Plan Employer Group Agreement.

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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 _____