

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"/> Your Choice - 3 Tier <input type="checkbox"/> Your Choice - 2 Tier <input type="checkbox"/> Steward Community Choice	<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"/> Your Choice - 3 Tier <input type="checkbox"/> Your Choice - 2 Tier <input type="checkbox"/> Carelink	<input type="checkbox"/> Total Replacement (Complete all sections) <input type="checkbox"/> Dual Option (Complete all sections)

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? _____

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).

LARGE GROUP EMPLOYER APPLICATION

MASSACHUSETTS

2) HEALTH PLAN INFORMATION

■ Requested effective date of coverage _____

■ Eligibility

Minimum number of hours required to be covered _____ (no fewer than 20).

Employees covered under a collective bargaining agreement are

Included Excluded Not Applicable

Retired persons are

Included Excluded

Other eligibility requirements: _____

Are domestic partners covered? Yes No

■ Waiting period, if any None 30 60 90 days after date of hire

Is it 1st of the month following satisfaction of waiting period Yes No

Other _____

■ Does your Group have an existing health plan(s)? Yes No

If yes, number of employees covered under your current plan(s) _____

Total number of employees covered through a spouse _____

Current carrier(s) _____

Is your health plan carrier currently requiring a premium rate increase?

Yes No If yes, what percentage? _____ %

■ Employer contribution (%) Employee _____ Two Person _____ Parent/Children _____
Family _____ Other _____

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

If yes, name of other carrier(s) _____

3) MEDICAL INFORMATION

■ Are you aware of any employees or dependents who have incurred \$10,000 or more in claims or been treated for a serious illness during the last 12 months?

Yes No If yes, please attach a list that includes the amount of claim and diagnosis for each claimant.

■ Are you aware of any employees not actively at work, or dependents who are or will be disabled on the requested effective date of coverage?

Yes No If yes, please attach a list to include year of birth, nature of sickness/disability and the date that the sickness/disability began (disabled dependents are those who are unable, because of sickness or injury, to carry on the activities of a person in good health who is the same age as the dependent).

■ If applicable, please attach a list of any employees, dependents or dependents of former employees who were covered under the prior plan and who have elected continuation of coverage under federal (COBRA) or state law. The list should include name, date of birth, date continuation began and reason for continuation of coverage.

LARGE GROUP EMPLOYER APPLICATION

MASSACHUSETTS

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) _____