Small Group Employer Application

TUFTS Health Plan

RHODE ISLAND

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 affiliated with any other company? ❑ Yes ❑ No

"Affiliated" is defined as any entity or person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

If yes, what is the total number of employees in all affiliated companies? ______________

List the name and location of the affiliated companies: ______________________

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 temporary or substitute 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.

D-U-N-S is a registered trademark of D&B.

Small Group Employer Application

RHODE ISLAND

TUFTS Health Plan

3) HEALTH PLAN INFORMATION

- **Please provide plan selected:** ______________________________

- **Requested effective date of coverage for the Group** ____________________

  (Future anniversaries will be set on the 1st of the month that the group was effective, e.g., effective 1/15/2009, renew 1/1/2010.)

- **Eligibility: Active, full time employees (working 17.5 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 (e.g., 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

- **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 ______________________________

- **Monthly premium of existing carrier** / **Employer Contribution (%)**

	Monthly premium of existing carrier	Employer Contribution (%)
Employee	$ __________	__________
Employee/Spouse	$ __________	__________
Employee/Children	$ __________	__________
Family	$ __________	__________

NOTE: Tufts Health Plan requires a minimum of 50% employer contribution toward individual coverage; 33% toward employee/spouse, employee/child(ren), and family monthly premiums.

Small Group Employer Application

RHODE ISLAND

TUFTS Health Plan

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.

- 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 dependent; and updated COBRA/Continuation of Coverage information.
  2) A completed Waiver Form for all eligible employees and dependents who are waiving their right to group health care coverage.
  3) Most recent Schedule C, Schedule K1, or 1120S Schedule K for all owners of each business.
  4) Most recent Quarterly Tax Wage and Report.
  5) W-4 form, including date of hire for any new hire not appearing on the tax documentation.
  6) COBRA—Groups with 20 or more employees, please provide a copy of the COBRA election form completed by the employee or copy of last payroll employee appeared on.

- **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 employee/spouse, employee/child(ren), or Family 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 Rhode Island 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 Rhode Island; 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.**
- **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 17.5 hours per week for the group;
  - They receive an annual W-2 Form; and
  - They are considered eligible employees as defined in Rhode Island General Law 20-50-3(m).
- **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 ______________________________