MASSACHUSETTS NEW CASE SUBMISSION CHECKLIST

TUFTS Health Plan

To help you set up your Tufts Health Plan coverage, simply submit the items listed below.

Tufts Health Plan must receive all proposed sold account paperwork 10 business days prior to the requested effective date.

- ☐ Small Group Employer Application completed in full
- ☐ All Member Enrollment Forms completed in full
- ☐ Most Recent WR1/Quarterly Wage Statement (Document if employees are full-time, part-time, no longer employed, or new hire) *May request a census
- ☐ If group is coming from a PEO, group must submit most recent payroll and a termination letter from the PEO stating Group is terminating their entire PEO relationship with them. Please contact your Sales Executive for additional questions regarding a PEO sale.
- ☐ Small Business Attestation (This form can be submitted when a WR-1 form is not required to be filed)
- ☐ Signed Verification of Alternative Coverage Forms
- ☐ Initial Deposit ACH Form completed in full, and
- ☐ Voided business check or clear image of voided business check with the completed initial deposit ACH form
- ☐ Or, a binder check for first month's premium

Please send all paperwork to:

Tufts Health Plan
ATTN: Broker Relationship Specialist
Mailstop B4
1 Wellness Way
Canton, MA 02021-1166

SMALL GROUP CHECKLIST

TUFTS Health Plan

Guidelines for Small Employer Group Application completion: The entire application must be completed in full and signed.

- ☐ Page 1, Section 1: Tax ID – Ensure this is filled in accurately, this is a nine-digit numeric field.
- ☐ Page 2, section 3: If the group elects "No" to the question "On the original effective date do you wish to waive the waiting period for all eligible employees?" The Date of Hire section must be completed on each individual employee application.
- ☐ Page 3, section 3: If there are COBRA members then the grid must be completed, including: Name, Type of Continuation, Reason for Continuation, and the Start and End Date of Continuation. Member enrollment forms are required to be submitted for all COBRA members.

Guidelines for Member Enrollment Form completion

- ☐ A physical residential address is required; a P.O. Box will not be accepted other than for a mailing address.
- ☐ The company address cannot be listed as an employee's residential address; the actual residential address is required.
  - — If the employee does live at the company address then a copy of the front and back of their driver's license is required to be sent in with their member application.
- ☐ All member enrollment forms must be signed and dated at the bottom. Plan selection should also be noted on each application.
- ☐ HMO enrollees must include their primary care name; otherwise they will only be covered for Emergency coverage until one is selected.
- ☐ As noted above, if the group does not wish to waive the waiting period on the original effective date then the Date of Hire must be listed on every employee's application.
- ☐ All dates of birth must be legible to ensure timely enrollment.
- ☐ Social security numbers are required to be listed and legible for all subscribers and dependents.
- ☐ Rhode Island Group Specific: If an employee is enrolling as an individual but indicates they are married, then Tufts Health Plan requires a spousal waiver.

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)

Total number of employees (ACA Definition): Number of full-time and full-time equivalent employees (FTE's), including any PT and seasonal employees who are employed at the time of the policy effective date working 30 or more hours per week.**

_____

Do you regularly employ at least one individual that is not an owner and/or spouse of an owner? ☐ Yes ☐ No

**If you have questions regarding these rules or any unique circumstances, please consult with your benefits advisor or legal counsel.

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

Please provide plan selected: ☐ HMO ☐ PPO
Plan Name: _____
Is this a Your Choice Plan? ☐ Yes ☐ No (If yes, please refer to language in section 5.)

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

Deductible: Plan Year_____or Calendar Year_____

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 minimum 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 waiting period, if any ☐ Date of hire ☐ 1st of the month following date of hire
☐ 30 days following date of hire ☐ 1st of the month following 30 days
☐ 60 days following date of hire ☐ 1st of the month following 60 days
☐ 90 days following date of hire
On the original effective date do you wish to waive the waiting period for all eligible employees? ☐ Yes ☐ No

3. HEALTH PLAN INFORMATION (Cont'd)

Does the Group have an existing health plan(s)? ☐ Yes ☐ No

If yes, current carrier(s)_____Renewal Date_____

Reason for transfer_____

Is the Group's existing health plan(s) through a PEO? ☐ Yes ☐ No

If yes, please submit a termination letter from PEO stating Group is terminating their entire PEO relationship with them.

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. These conditions do not apply to applications submitted during the limited enrollment period established by 45 CFR 147.104(b)(1).

Monthly premium of existing carrier

EE $_____EE/SP $_____EE/CH $_____EE/CH (ren) $_____Family $_____

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 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.

  *These conditions do not apply to applications submitted during the limited enrollment period established by 45 CFR 147.104(b)(1).

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 employees: 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 Your Choice product is a tiered provider network product. It cannot be sold without a signed employer group application or renewal attestation confirming that the client will not fund an HRA.
- Steward Community Choice is a limited provider network product. Employer group must have a work site in the Steward Community Choice Service Area. Employees must reside or physically work in the Steward Community Choice Service Area.
- 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. This group agrees to notify Tufts Health Plan promptly of any changes to this information.

Signature_____

By (print) _____

Title (print) _____

Date _____

TUFTS Health Plan

TUFTS Health Plan

Initial Deposit Authorized Clearing House (ACH) Authorization Form

Company Name: _____

Company Address: _____

_____

Group Effective Date: _____

Bank Name: _____

Bank ABA Routing Number (should be 9 digits): _____

Bank Account Number (must be a business account): _____

Bank Account Type: ☐ Checking ☐ Savings

Premium Amount to Withdraw: _____

There is no formal notification of when the withdrawal will occur. Please have funds available as ACH is pulled 1-3 business days after Underwriting has approved your group.

Signature Required:

By signing below, I authorize Tufts Associated Health Maintenance Organization, Inc. d/b/a Tufts Health Plan and its affiliates to make electronic funds transfers from my business checking or savings account to withdraw the first month's deposit premium for group health insurance in the amount indicated and that the EFT withdrawal level on this account is sufficient to cover the amount indicated. I understand that this authorization is for the first month's premium only. I will be responsible for sending future premium payments to Tufts Health Plan unless I sign up for eBilling access. I have the right to terminate this agreement by sending a written notification of my intention thirty (30) days prior to the effective date of coverage. I have read this agreement and fully understand my rights and obligations under this agreement.

Please attach a voided business check or a clear image of a voided check with your completed ACH Authorization Form.

_____Initial here to confirm you have notified your bank that Tufts Health Plan (ACH Company ID: 1042985923) will be withdrawing funds from this account. The withdrawal of this ACH authorization will appear as "TAHMO" within your banking institution notification.

_____Initial here if you would like to sign up for eBilling, which will allow you to make future monthly payments electronically. A signed web authorization form must be included with the new business paperwork.

_____ _____

Authorized Signature Date

_____ _____

Print Name Title

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Tufts Health Plan:

- Provides full and equal access to covered services under the federal *Americans with Disabilities Act of 1990* and Section 504 of the federal *Rehabilitation Act of 1973*. This includes free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of the above services, have questions regarding any provider directory information, or would like to report an inaccuracy or network access issue, please contact Tufts Health Plan Member Services at 800.462.0224. To report provider directory inaccuracies electronically, please visit **https://tuftshealthplan.com/find-a-doctor** and select your plan. Search or select the Provider whose information you believe needs updating and click *"Tell us if something needs to change".*

Please note that if you have complaints regarding provider directory inaccuracies or provider network access issues, you also have the right at any time to contact the Commonwealth of Massachusetts Division of Insurance at (877) 563-4467, Option 2 or **www.mass.gov/doi**.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
1 Wellness Way Canton, MA 02021-1166
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@point32health.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services:
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

tuftshealthplan.com | 800.462.0224

848041518-THP-OCR-NOTICE-02/2022

For no cost translation in English, call the number on your ID card.

Arabic . للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang kreyòl ayisyen, rele nimewo ki sou kat ID ou a.

Italian Per richiedere la traduzione in italiano senza costi aggiuntivi, chiamare il numero indicato sulla carta di identità.

Japanese 日本語の無料翻訳については**ID**カードに書いてある番号に電話してください。

Khmer (Cambodian) **សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។**

Korean 한국어로 무료 통번역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo bąąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'é bee nééˊ ho'dílzingo nantinígíí bikáá'.

Persian. برای ترجمه رایگان فارسی به شماره تلفن مندرج در کارت شناسائی تان زنگ بزنید

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para o português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Para servicios de traducción gratuitos en español, llame al número que aparece en su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

New Members Register at Tuftshealthplan.com for fast access to your secure online account and personal benefit information.

Please fill in the "employee" sections of this membership application completely. Failure to do so could delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon. If you need a temporary ID, please use the yellow copy of this completed form.

Employer Section

Your employer must fill out this section.

Employee Section

- Personal Information: Complete all enrollment information. For all plans, select a primary care provider (PCP), be sure to fill out this section for all members, including dependents.
- Product Code: Please be sure to fill in the correct product code for the plan you have selected.
- Primary Care Provider: If your plan requires you to choose a PCP, it is important that you select one right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are an established patient of the PCP you have listed. (You are an established patient if you have routinely received health care services from this provider in the past.) If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam. You will then need to transfer your medical records to your new PCP.
- Other Health Coverage: If you have other or additional insurance (such as Medicare), please check the correct box and fill in the requested information. If you do not have any other insurance, be sure to check the "No" box.

When the Application is Complete

- Give the application to your employer.
- Employee keeps the yellow copy. This is also your temporary ID.
- Employer keeps the pink copy.
- Employer mails the original white copy to:
  Tufts Health Plan
  P.O. Box 506
  1 Wellness Way
  Canton, MA 02021-1166

If You Need Emergency Care

If a health care emergency occurs, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP.

Notices

By enrolling, you understand and agree that if you or any of your enrolled dependents obtain a health care benefit or payment that you are not entitled to receive, or if you knowingly present a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including the cost of the investigation.

Tufts Health Plan arranges for the provision of health care services through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan. Tufts Health Plan does not directly provide health care services.

Product Codes

Write the corresponding letter in the product box in the member section of the enrollment application.

A - HMO Premium
B - HMO Value
C - HMO Basic
D - HMO Choice Copay
E - Advantage HMO
G - Advantage HMO Saver
H - POS
I - POS Choice Copay
J - EPO
K - EPO Choice Copay
L - PPO
M - Advantage PPO
O - Advantage PPO Saver
P - Navigator by Tufts Health Plan
Q - Carelink
R - Select HMO
S - Select Advantage HMO
T - Rhode Island Healthpact
U - Your Choice HMO
V - Your Choice PPO
W - Steward Community Choice
LPC - Lifespan Premier Choice

We speak 140 languages.
Call Member Services.

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl
เรือ อิหยาย ภาษาไทย

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the Doctor Search feature. If you need help filling out this form, call a Member Services Specialist.

Member Services:

800.462.0224

MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE AREAS MARKED IN BLUE WILL CAUSE A DELAY IN ENROLLMENT.

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 506 •1 Wellness Way • Canton, MA 02021-1166

EMPLOYER SECTION

Group/Company Name_____ Group Number_____

Office Location_____ Date of Hire_____ Effective Date of Coverage_____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify)_____ Qualifying Event Date_____

MEMBER SECTION

PRODUCT (Select corresponding letter from the list on the front page)_____ Other _____

Last Name_____ First Name_____ Middle Initial_____ Primary Language_____

Employee Social Security Number (required)_____ Date of Birth (MM/DD/YYYY)_____/_____/_____ Gender: ❑ Male ❑ Female

Mailing (Home) Address_____ City_____ State_____ ZIP_____

Email Address_____ Home Telephone (_____)_____ Work Telephone (_____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Family ❑ Other_____

Primary Care Provider First Name_____ Last Name_____ PCP ID#_____ Are you an established patient of this PCP? ❑ Yes ❑ No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (Include first and last name.)	Check if currently used for primary care	PCP ID #
❑ Spouse ❑ Domestic Partner			- -		☐	
Child/Dependent			- -		☐	
Child/Dependent			- -		☐	
Child/Dependent			- -		☐	
Child/Dependent			- -		☐	
Child/Dependent			- -		☐	

Please check if you are using additional membership applications for additional dependent children. ☐

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan_____ Name of Plan Holder_____ Health Plan Number_____ Effective Date_____

Names of Family Members Covered_____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer _____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature_____ Date_____ Benefits Dept. Signature (required)_____ Telephone_____ Date_____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.

MASSACHUSETTS VERIFICATION OF ALTERNATIVE COVERAGE

TUFTS Health Plan

Please fill out this form completely if you are waiving coverage.

EMPLOYEE INFORMATION

Employee Name:_____

Employer Group:_____

REASONS FOR WAIVER

I waive my right to participate in Tufts Health Plan offered at this time by or through my employer because:

- ☐ I am covered under my spouse's health plan.
- ☐ I am covered under another health plan sponsored by my company.
- ☐ I am covered by another health plan not sponsored by this employer.
- ☐ I do not wish to enroll in any type of medical coverage at this time.
- ☐ Other: (Must provide details)_____

If you have selected that you have coverage elsewhere please provide the following:

Carrier Name:_____

Subscriber Name:_____

SIGNATURE

If you are declining enrollment for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in Tufts Health Plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself as well as your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I understand that if I later choose to enroll, I must meet Tufts Health Plan's requirements, if any, applicable to late enrollees.

By signing this document, you certify that the information contained in this form is complete and true.

_____

Name

_____ _____

Signature Date

WEB AUTHORIZATION FORM

Employer Group Name: _____ ("Employer Group"), hereby authorizes and requests that Tufts Health Plan provide, to the individual designated below, electronic access to information submitted to Tufts Health Plan by the above named Employer Group related to health care coverage provided to members covered under Employer Group, and allow this individual to perform certain functions pertaining to Employer Group on the Tufts Health Plan website, including but not limited to accessing enrollment and eligibility information and performing website functions on Employer Group's behalf. Pursuant to this Web Authorization Form, Tufts Health Plan will grant access to the Senior Access Administrator designated below and to Access Administrators and Authorized Users designated by the Senior Access Administrator or Employer Group. Tufts Health Plan may provide these designated individuals with access to information relating to the Employer Group's past groups, current groups and any future groups as long as this Web Authorization Form is in effect. The Senior Access Administrator will be responsible for communicating to Tufts Health Plan the identity of all additional Access Administrators and Authorized Users whom Employer Group authorizes to access Employer Group enrollment and eligibility information and perform website functions on behalf of the Employer Group. Employer Group hereby grants that authority and responsibility to the Senior Access Administrator designated below. Employer Group understands that it is responsible for compliance with all applicable federal and state requirements concerning the confidentiality of health care information, and that Employer Group retains ultimate responsibility for the actions and use of that information by those designated pursuant to this Web Authorization Form. Employer Group agrees to take certain precautions, comply with certain practices, implement certain procedures and enter into any other agreements or documents required by HIPAA and other applicable law for the purposes of guarding data integrity and safeguarding the confidentiality of health care information. Employer Group understands that Tufts Health Plan will require that any person Employer Group designates as a Senior Access Administrator, Access Administrator or Authorized User must accept certain Terms of Use agreeing to comply with, among other things, HIPAA and other requirements concerning the confidentiality and security of private health care information. Employer Group further understands that it is Employer Group's responsibility to inform Tufts Health Plan of any changes to the Senior Access Administrator designation below and that Tufts Health Plan or Employer Group can terminate this Web Authorization Form at any time upon prior written notice.

The date of signature will be deemed the effective date of this Web Authorization Form unless otherwise stated.

AUTHORIZATION FORM SIGNATURE REQUIREMENTS:

For the purposes of website registration and signature requirements for this Web Authorization Form, the individual signing this document must be an individual empowered by that entity to bind the entity in this legal agreement. (eg: CEO, CFO, General Counsel, President, VP, Partner, Treasurer) If you have submitted an on-line registration request, the Signatory identified below must also be the person identified as the Signatory on your on-line registration application.

I certify that I am an authorized representative empowered to bind Employer Group in this legal document. I have read, understand, and agree to the terms of this Web Authorization Form:	Senior Access Administrator: Must be an officer or employee of your company. The Senior Access Administrator cannot be a broker.
_____ Print Name*	_____ Print Name*
_____ Print Title*	_____ Print Title*
_____ Signature*	_____ Phone*
_____ Date*	_____ E-Mail Address*
_____ Name of Employer Group*	*Required Fields
_____ E-Mail Address*	

For Internal Use Only:

Group ID#_____ #eligibles_____ Sales Rep Name_____ Sales Rep Signature_____

Tufts Health Plan Enrollment & Premium Billing
P.O. Box 506 • 1 Wellness Way • Canton, MA 02021-1166 • Telephone: 1-866-300-1712 • FAX: (617) 923-5898