NEW GROUP APPLICATION FOR MEDICARE ELIGIBLE WORKING-AGED EMPLOYEES

TUFTS Health Plan

PLEASE ANSWER EVERY QUESTION COMPLETELY

Effective date:_____(Will renew in January)

Tufts Health Plan Sales Representative:_____

PLEASE CHECK THE BOX FOR YOUR CHOSEN PLAN BELOW:

Tufts Medicare Preferred HMOPrime
Group Rx _____ Group Rx Plus____
Group Standard Rx___ Group Rx Custom ___

Tufts Medicare Preferred HMO Custom Prime
Group Rx _____ Group Rx Plus____

Tufts Medicare Preferred HMOValue Rx___

Tufts Medicare Preferred HMO Basic Rx Custom_____

Tufts Medicare Complement (TMC)
Rx_____ Rx Plus___ No Rx___

Tufts Medicare Complement Value Rx___

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: _____

GROUP INFORMATION (CONTINUED)

SIC code: _____

Organization type: q State Government q Local Government q Publicly Traded
q Private q Nonprofit q Church Group q Other

Date business established: _____ Tax I.D. number: _____

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? _____

Is this group a: q Corporation q Partnership q Sole Proprietorship q Other

If other, please specify: _____

Is the group a subsidiary, an affiliate or branch of a parent company with more than 50 employees? q Yes q No

If yes, what is the total number of employees in all locations? _____

Subsidiaries or affiliates to be covered and locations: _____

Are there office locations other than the one listed above? q Yes q No

If yes, what are they? _____

INFORMATION RELATED TO MEDICARE SECONDARY PAYER (MSP)

Group attests that Group has fewer than 20 employees as defined in the Medicare Secondary Payer regulations at 42 CFR § 411.170:

> An employer is considered to employ 20 or more employees if the employer has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

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).

BROKER DESIGNATION, IF APPLICABLE

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.

Broker phone number:_____Broker fax number: _____

Broker email address: _____

Make commissions payable to: _____

Broker Tax I.D. Number: _____

Signature: _____

IMPORTANT

Group represents and warrants that Group is actively engaged in business, and 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 the effective date mutually agreed upon between Tufts Health Plan and the employer, however coverage will renew on January 1 every calendar year. Group further acknowledges that Group has fewer than 20 employees as defined in the Medicare Secondary Payer statute 42 U.S.C. § 1395y. Group will immediately notify Tufts Health Plan if Group's employee count according to the Medicare Secondary Payer statute were to change so that it is no longer eligible for Medicare to be the primary payer. In the event of this change, Group acknowledges that the Group's Medicare eligible employees would no longer be eligible for this product. The Group acknowledges that it offers the coverage described under this agreement to all of its full-time Medicare eligible employees who live in the commonwealth. The Group further acknowledges that it does not make a smaller premium contribution percentage amount to any employees than it makes to any other employees who receive an equal or greater total hourly or annual salary for each specific health plan offered. However, the Group may establish separate contribution percentages for employees covered by collective bargaining agreements. Group acknowledges that if 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. 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)_____