

RHODE ISLAND NEW CASE SUBMISSION CHECKLIST



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 Wage and Tax documents (properly coded: enrolled, waived, PT, etc.)
or Third party payroll report (properly coded: enrolled, waived, PT, etc.)
- Most recent documentation of all owners (Sched C, Sched K1, or 1120S)
*May request a census
- Small Business Attestation
(This form can be submitted when Wage and Tax documents are not required to be filed.)
- Signed Waiver Forms from each member waiving coverage
- Binder Check for first month's premium
- Pediatric Dental Attestation Form: (Complete and sign if the group offers a Pedi-Dental compliant plan with another carrier and wishes to opt out of Tufts Health Plan pediatric dental coverage.)

Please send all paperwork as well as a live binder check to:

Tufts Health Plan - New Business Sales Operations
Attn: Lori Ann Ball
75 Fountain Street, Ste 100
Providence, RI. 02903

RHODE ISLAND SMALL GROUP EMPLOYER APPLICATION FOR GROUPS WITH 2-50 EMPLOYEES



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 or eligible to file a combined state tax return with another legal entity?

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 locations (being either subsidiaries; or entities eligible to file a joint state tax return)? _____

List the name and location of all locations (being either affiliated companies, subsidiaries, 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): What was the average number of full-time and full-time equivalent employees (FTE's) working 30 or more hours per week that your business employed during the previous calendar year determined in accordance with applicable federal law and regulation** _____

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

**The following federal regulation and guidance provide information on how to count full-time and FTE's. 26 CFR 54.4980H which may viewed at http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3502c48bf08b3597225a876ab7da198f&mc=true&n=pt26.19.54&r=PART&ty=HTML#se26.19.54_14980h_60

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 Lifespan Premier Choice plan? Yes No (If yes, please refer to language in section 5.)

Requested effective date of coverage for the Group _____

(Must be 1st of the month effective date)

Deductible: Plan Year _____ or Calendar Year _____

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.

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? _____

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 (CONTINUED)

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. 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 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.

*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 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 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.
- ◆ 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).

5. REPRESENTATION AND WARRANTY (CONTINUED)

- ◆ The LifeSpan Premier 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.
- ◆ 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 _____



WELCOME TO TUFTS HEALTH PLAN



Please fill in the “subscriber” sections of this membership application completely so we do not delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon.

Employer Section

Your employer must fill out this section.

Employee Section

- **Personal Information:** Complete all enrollment information. Please 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. (Please use chart on the right.)
- **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 a current patient of the PCP you have listed. (You are a current 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.

- **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.
- Employer mails the form to:
Tufts Health Plan
P.O. Box 9186
Watertown, MA 02471-9186

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 may lose your health care coverage and 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.

We collect email addresses and cell phone numbers (“your information”) as part of the registration process. We may use your information to notify you of online activity related to the security and privacy of your accounts, such as, retrievals of username, etc. In addition we may use your information to send you health and wellness information and other updates that might be of interest to you as members of Tufts Health Plan. On certain occasions we may also share your information with providers in our network so that they may send you information that describes health-related products and/or services offered by the provider and included in your plan of benefits, enhancements to your plan, and/or benefits and services available to you as a health plan member that add value to, but are not part of, your plan of benefits. Each time we or any such provider sends health and wellness information and other updates, you will be given the opportunity to opt-out of receiving similar emails or cell phone communications in the future. Please note that you cannot opt-out of receiving emails that notify you of online activity since these are necessary to protect the privacy and security of Web accounts.

Product Codes

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

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

We speak over 200 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
ᱥᱟᱱᱛᱟᱲ ᱠᱟᱨ

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 Representative.

Member Services:
800.462.0224

MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE FORM 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 9186 • Watertown, MA 02471-9186

EMPLOYER SECTION PLEASE WRITE IN YOUR 8 DIGIT GROUP NUMBER BELOW

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 _____

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

Last Name _____ First Name _____ Middle Initial _____

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

Residential Address (required) _____ City _____ State _____ ZIP _____

P.O. Box (optional) _____ City _____ State _____ ZIP _____

Email Address _____ Home/Work Telephone (_____) _____ Cell Phone (_____) _____ Primary Language _____

Marital Status: Single Married Divorced Domestic Partner Type of Coverage Requested: Individual Family Other _____

Primary Care Provider First Name _____ Last Name _____ PCP/ NPI # _____ Is this your current PCP? Yes No

| Members Enrolling First Name / 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 NPI # |
|--|------------|-------------------------------|--|--|---|-----------|
| <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner | | | - - | | <input type="checkbox"/> | |
| Child/Dependent | | | - - | | <input type="checkbox"/> | |
| Child/Dependent | | | - - | | <input type="checkbox"/> | |
| Child/Dependent | | | - - | | <input type="checkbox"/> | |
| Child/Dependent | | | - - | | <input type="checkbox"/> | |
| Child/Dependent | | | - - | | <input type="checkbox"/> | |

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.

Subscriber Signature _____ Date _____ **Employer Signature** (required) _____ Telephone _____ Date _____

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, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- ▶ Provides 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 these services, contact Tufts Health Plan at 800.462.0224.

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.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

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>.

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.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

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) សម្រាប់សេវាកម្មប្រយោជន៍ឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສຳລັບການແປພາສາ ບັນພາສາລາວທີ່ບໍ່ໄດ້ສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo bąąh ilíni da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'é bee née ho' dílzingo nantiniígíí bikáá'.

Persian. برای ترجمه رایگا فارسی به شماره تلفن مندرج در کارت شناسایی 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 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 Por servicio de traducción gratuito en español, llame al número de 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.



705 Mt Auburn Street - Watertown, MA 02472
tuftshealthplan.com - 800.462.0224

RHODE ISLAND VERIFICATION OF ALTERNATIVE COVERAGE



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

Employee Information

Employee Name: _____

Social Security Number: _____

Employee 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 Medicare.
- I am covered by COBRA.
- I do not wish to participate at this time.
- Other: (Must provide details) _____

Who is waiver for (Please check all that apply): Employee Spouse Child/Children

Signature

If you are declining enrollment for yourself or for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request enrollment or obtain more information, contact your employer.

Name

Signature

Date

RHODE ISLAND SMALL BUSINESS ATTESTATION



This document is to be provided to Tufts Health Plan when a Quarterly TaxWage and Report is not required to be filed.

Employer Group Name: _____

Eligibility of Group: As a corporate officer of the above referenced Employer Group, I hereby attest that this Employer Group meets the requirements of a Rhode Island Small Group as defined in the Rhode Island Small Employer Health Insurance Availability Act Chapter 27-50.

“Small employer” means, except for its use in § 27-50-7, any person, firm, corporation, partnership, association, political subdivision, or self-employed individual that is actively engaged in business including, but not limited to, a business or a corporation organized under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of another state that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week of thirty (30) or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual.

Eligibility of Subscribers: “Eligible employee” means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer’s sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this eligibility criterion is applied uniformly among all of the employer’s employees and without regard to any health status-related factor. The term includes a self-employed individual, a sole proprietor, and a partner of a partnership, if the self-employed individual, sole proprietor, or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than seventeen and one-half (17.5) hours per week. Any retiree under contract with any independently incorporated fire district is also included in the definition of eligible employee. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered “eligible employees” for purposes of minimum participation requirements pursuant to § 27-50-7(d)(9).

I acknowledge in my capacity as a corporate officer, if the Employer Group commits fraud, or misrepresents information regarding eligibility as a Rhode Island Small Group, Tufts Health Plan reserves the right to terminate coverage, retroactive to the original effective date of coverage

Signature (must be a corporate officer)

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: _____ Print Name* _____ Print Title* _____ Signature* _____ Date* _____ Name of Employer Group* _____ E-Mail Address* | Senior Access Administrator: Must be an officer or employee of your company. The Senior Access Administrator cannot be a broker. _____ Print Name* _____ Print Title* _____ Phone* _____ E-Mail Address* *Required Fields |
|---|--|

For Internal Use Only:
Group ID# _____ #eligibles _____ Sales Rep Name _____ Sales Rep Signature _____

PEDIATRIC DENTAL ATTESTATION FORM



PURPOSE

In order for Tufts Health Plan to support your request to not include the pediatric dental benefit on your plan, in accordance with federal law we will need the following confirmation from you. This statement should be completed and then signed by an officer of your company. This is being requested to confirm that all members covered under your Tufts Health Plan plan have an Exchange Certified pediatric dental plan outside of Tufts Health Plan that covers each member for the dates for which the Tufts Health Plan plan is effective. Final sale is dependent upon receipt of this signed attestation. Exchange Certified dental plans, referred to as Qualified Dental Plans (QDPs) are listed on the Division of Insurance website.

Please note: This attestation is deemed part of the employer group/administrative services agreement (as applicable) between Tufts Health Plan and Plan Sponsor. Please attach additional pages for your membership as needed.

| # | Census | Member's Pediatric Qualified Dental Plan (QDP) Provider | | Effective Date of Coverage | |
|----|-------------|---|-----------|----------------------------|----|
| | Member Name | Dental Carrier Name | Plan Name | From | To |
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
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PLAN SPONSOR ATTESTATION

The undersigned, as duly-authorized representative for _____ (“Plan Sponsor”), hereby attests to Tufts Health Plan that each member covered under the Tufts Health Plan plan has obtained separate pediatric dental coverage from an Exchange Certified dental plan that covers the member for the dates for which the Tufts Health Plan plan is effective.

Certified by: _____ Date: _____
Signature