LARGE GROUP EMPLOYER APPLICATION

RHODE ISLAND

TUFTS Health Plan

PRODUCT (Check the appropriate box)

☐ HMO	☐ Premium	☐ Option (Complete sections 1, 2, 5 and 6)
	☐ Value	☐ Total Replacement (Complete all sections)
	☐ Choice Copay Option	☐ Joint Offering HMO/HMO (Complete all sections)
	☐ Basic	☐ Dual Option (Complete all sections)
	☐ Advantage	☐ Right Choice
	☐ Advantage Saver	☐ Lifespan Premier Choice
☐ PPO	☐ Premium	☐ Carelink
	☐ Value	☐ Total Replacement (Complete all sections)
	☐ Basic	☐ Dual Option (Complete all sections)
	☐ Advantage	☐ Right Choice
	☐ Advantage Saver	☐ Lifespan Premier Choice

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 _____

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?*_____

*The following federal regulation and guidance provide information on how to count full-time and FTE's: 26 CFR 54.4980H which may viewed here: 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

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).

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2) HEALTH PLAN INFORMATION

■ Requested effective date of coverage _____

Deductible: ☐ Plan Year ☐ Calendar Year

■ Eligibility

Minimum number of hours required to be covered _____ (no fewer than 17.5).

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 ☐ 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

■ 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 with alternative creditable coverage_____

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.

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4) CONFIRMATION OF INFORMATION

- If the employees contribute toward the cost of the insurance, at least 75% of the eligible employees (minus those with alternative creditable coverage) must be enrolled in a group sponsored plan on the effective date. Failure to meet the participation requirements may result in rate adjustments.
- 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. This group agrees to notify Tufts Health Plan promptly of any changes to this information.

Signed at (city & state) _____

Name of applicant/employer _____

Date signed _____ By (signature/title) _____

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, 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.

tuftshealthplan.com | 800.462.0224

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 κάρτας 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) **សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។**

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

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo bą́ąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian. **برای ترجمه رایگا 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 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.