YOUR CHOICE WITHOUT HRA ATTESTATION

TUFTS Health Plan

PURPOSE

You have selected a Your Choice plan without a Health Reimbursement Account (HRA). This plan provides you with a lower rate. This form provides Tufts Health Plan with documentation that you will not pair an HRA with this plan.

PLAN SPONSOR INFORMATION

First Name _____ Middle Name _____ Last Name _____

Title _____

Employer/Plan Sponsor _____ Group Number(s) _____

Address _____ City, State _____ Zip Code _____

Email Address _____ Phone _____

PLAN SPONSOR ATTESTATION

I, the undersigned, duly-authorized representative for_____ ("Group"), acknowledge that Group has applied for the lower priced Your Choice plan without HRA. Group hereby attests that it will not fund an HRA, and its employees will be fully financially responsible for the member cost-sharing under the Your Choice plan. Group also acknowledges that by paying the first month's premium for this Your Choice coverage, it is agreeing that, if it does fund an HRA, Tufts Health Plan has the right to adjust Group's premium back to the effective date, and Group will pay Tufts Health Plan both retrospective and prospective premium differences.

First Name _____ Middle Name _____ Last Name _____

Title _____

Signature _____ Date _____