Corporate Office
141 Longwater Drive, Suite 112
Norwell, MA 02061
(781) 228-2222

New Case Submission Checklist
HEALTH NEW ENGLAND

1.	The **employer** completes and signs the **HSA Membership Application**	☐
2.	The **employer** completes and signs the **Employer Group Application**	☐
3.	The **employer** must provide a copy of **the present carrier's current premium statement**	☐
4.	**The employer must provide a copy of the following information:** **If a sole Proprietorship** • Wage Detail Report from DUA QUEST System/WR-1 Mass. Quarterly Payroll (if filed) • 1040 Schedule C **If a Corporation or Partnership** • Wage Detail Report from DUA QUEST System/WR-1 Mass. Quarterly Payroll (most recent) **If a New Business** • If tax information is not available, owner must provide copies of DBA Certificate, Business License, Articles of Incorporation or other proof deemed appropriate by **HNE**	☐
5.	Each eligible **employee** completes a **HNE ENROLLMENT/ADD/TERMINATION FORM** including its choice of **HNE Primary Care Physician** for each family member.	☐
6.	Each eligible **employee** applying for a waiver completes a **Waiver of Coverage Form.**	☐
7.	If selecting a "Metallic" plan without Pediatric Dental, the **employer** must include proof of enrollment in a Pediatric Dental Plan (Not required if purchasing Pediatric Dental through HSA)	
8.	Enclose copy of **Proposal/Quote** showing rates for desired effective date	☐
9.	Pay your first premium, $5 monthly service fee and $125 annual membership fee: • Pay over the phone: (781) 228-2222. Payment Confirmation #:_____ -or- • Complete Electronic Payment Request Form -or- • Enclose check payable to HSA *(Receipt of payment does not guarantee coverage. HSA must receive completed enrollment materials by the carrier deadline)*	☐
10.	Enclose your Annual Membership Fee of **$125 (payable to HSA)**, (see step 9). **-or-** If enrolling through an **Association or Chamber of Commerce, please note the name**: _____ (*If not already a member of a participating Association or Chamber of Commerce, additional requirements may apply, such as completing a membership application and paying dues.)*	☐
11.	Send all required documents (including this checklist) to: **Corporate Office** 141 Longwater Drive, Suite 112 Norwell, MA 02061 Sales Rep: Contact Info:	☐

PLEASE NOTE: Complete applications and premium payment for new business must be received by HSA at least 5 business days prior to the requested effective date.

All coverage will be effective on the 1st day of the month. Once your enrollment has been approved and processed, you will receive a member confirmation by mail with your account number. Your permanent ID cards will be issued to you directly by the carrier. **Permanent ID cards generally take 7-10 business days from date your enrollment was approved and processed.**

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Please complete each section of this application. Failure to do so could delay enrollment.

Employer information

Employer name _____ Date business established (Mo./Yr.) ____/____

Employer address _____

City _____ State _____ Zip _____

Owner/principal contact name (first and last) _____ Title _____

Business Phone _____ Cell phone _____ Fax _____

Email _____ Website _____

Billing address _____

City _____ State _____ Zip _____

Type of business ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ LLC ❑ Other: _____

Nature of business: _____

Employer tax ID# _____ SIC code _____

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

Number of full-time employees (30 hours or more per week; including owner) _____

Number of part-time employees (less than 30 hours per week) _____

Quote # (from Group Proposal) _____

Certification and Disclosures

1. The company named above is a bona fide business and not in operation for the sole purpose of obtaining health insurance.
2. All enrollees are actively working for financial compensation and are covered by Worker's Compensation as required by law.
3. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
4. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
5. Payments not received by the 10th of the month are subject to a late fee, currently $25.
6. Payments not received by the 20th of the month are subject to a pending termination fee, currently $50.
7. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier. Reinstatements are subject to a reinstatement fee, currently $50.
8. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $20.
9. Member firms must maintain good standing in their respective Business Association or Chamber of Commerce to participate in the group insurance programs offered through HSA.
10. HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.
11. HSA Insurance charges a monthly service fee per account.

I certify that the information on this form is true and complete, that I understand and agree to the above administrative requirements, and that I have the legal authority to sign on the company's behalf.

Signature _____ Title _____ Date _____

Broker name (if applicable) _____
Address _____
City _____ State _____ ZIP _____

For office use only
Account representative _____

Health New England

HSAinsurance

Employee Enrollment Form

Employer information

Employer name _____ Group # _____

Employee information

Type of Enrollment: ☐ New hire ☐ Open enrollment ☐ COBRA ☐ New group ☐ Qualifying event: _____

Date of hire ___/___/____ Requested effective date ____/___/____

Employee name (first and last) _____ DOB ____/____/____ Sex ☐ M ☐ F

Employee address _____ Apt # _____ SSN ____-____-____

City _____ State _____ ZIP _____

Email _____ Primary language _____

Home Phone _____ Cell Phone _____ Fax _____

Primary care provider (PCP) name _____ PCP ID # _____ Existing patient ☐ Yes ☐ No

If the PCP you select is not in our network, we will select a PCP we think is right for you. You may change your PCP at any time.

***What is your race/ethnicity?**

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Coverage type (select one)

☐ Self ☐ Individual/Spouse ☐ Individual/Child or Children ☐ Family

Please write your plan selection below:

☐ _____

**Why is this question being asked? The Center for Medicare and Medicaid Services (CMS) has established goals for improving health care quality and reducing racial and ethnic disparities in health care. The goal is to remove any barriers to fair and unbiased treatment for all. By collecting information about your race and ethnic background, CMS may be able to identify possible issues that affect the care or treatment you receive. This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment and will remain confidential. A response to this question is optional.*

Please provide **ALL** the information below for any eligible dependents you wish to enroll. You can use additional enrollment forms if you need more room:

Spouse name (first and last)_____ DOB ____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name _____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Dependent name (first and last)_____ DOB ____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Dependent name (first and last)_____ DOB ____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Dependent name (first and last)_____ DOB ____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

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Dependent name (first and last)_____ DOB ____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

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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 **Health New England** coverage. I assign benefits to **Health New England** for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan, or other coverage. I agree that **Health New England** and its providers may obtain and/or release my/our medical information to administer benefits, evaluate medical care provided, conduct quality assurance reviews and analysis, conduct medical research, and/or as required by law. I understand that for **Health New England** coverage to be in effect, all care, supplies, and services must be authorized, and/or provided by in-network providers.

ALL INFORMATION MUST BE COMPLETED AND SIGNED BEFORE PROCESSING CAN BEGIN.

Signature _____ Date ____/____/____

Employer Group Authorization Form

Complete ONLY if enrolling in Health Savings Account or Health Reimbursement Arrangement

Health Savings Account / Health Reimbursement Arrangement Plan Setup

Please complete this form to select **HealthEquity** as the administrator for your organization's Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) plan.

Company Information

Company Name: _____

Primary Contact Name & Phone Number: _____

Plan Start Date: _____

Please Select One: ☐ **Health Savings Account (HSA)** ☐ **Health Reimbursement Arrangement (HRA)**

To Be Completed by Health New England

Group Number: _____

Division Number: _____

Benefit Package: _____

Health New England Sales Contact: _____

Underwriting Date and Signature _____

*** Send the completed form to your Health New England Sales Representative**

HSAinsurance

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Waiver of Coverage Form

Company Name _____

Employee Name: _____ Date of Birth_____

I waive health coverage for myself and dependents (if any).

Reason for Declining Coverage:

- ☐ I am covered through spouse's employer
- ☐ I am covered through parent's health plan
- ☐ I am 65 or over and covered by Medicare
- ☐ I am covered by Mass Health
- ☐ I am covered by another health plan offered by my company
- ☐ I am covered by another health plan offered by a second employer
- ☐ I am covered by a veterans program
- ☐ I am covered by a non-group health plan
- ☐ I do not wish to participate at this time
- ☐ I live in the town of _____ that is not in the health plan service area
- ☐ Other; please specify:_____

Employer Name: _____

Insurance Carrier: _____

_____ _____
Employee Signature Date

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Electronic Payment Request Form

New Client? Pressed for time? Call (781) 228-2222 (8:30am-5:00pm, M-F) to quickly set up electronic payments. Just have your bank account and routing numbers ready. Or, complete this form:

Client Information:

Client Name: _____ Client Email: _____

New Client: Quote number and/or Application ID: _____

Current Client: 6 Digit HSA Account number: _____

Select payment type:

☐ **Recommended for new clients:** Withdraw both first month payment and recurring monthly payments
☐ First month payment only

If requesting recurring monthly payments, select date for withdrawal.

☐ 15th of the month ☐ 24th of the month

All outstanding balances owed, including fees, will be transferred at that time.

Bank Information:

Bank Name: _____ City: _____ State ____ Zip: _____

Name on Account: _____

Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings

Authorization:

I (we) hereby authorize HSA Insurance to initiate debit entries for my (our) checking account and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until HSA Insurance has received written notification from me (us) of its termination in such time and in such manner as to afford HSA and DEPOSITORY a reasonable opportunity to act on it. Note: all written debit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

Authorized Signer _____ _____
Sign Name Print Name and Title

Date: _____ Client Telephone: _____

Return Form

Please fax or secure email the completed form to: (781) 848-7020 or enrollment@hsainsurance.com
For changes to existing bank information, please contact Customer Service: (781) 228-2222.