Group Membership Application

Please complete each section of this application in full. ***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 ☐ Other: _____

Nature of business _____

Employer Tax ID # _____ SIC code (4 digits) _____

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

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

Requested effective date ___/___/___ Quote # (from Group Proposal) _____

Plan selection

☐ *Tufts Health Direct Platinum*
☐ *Tufts Health Direct Gold 1000*
☐ *Tufts Health Direct Gold 2000*
☐ *Tufts Health Direct Silver 2000*
☐ *Tufts Health Direct Silver 2000 HSA*
☐ *Tufts Health Direct Silver 2500 with Coinsurance*
☐ *Tufts Health Direct Bronze 2750*
☐ *Tufts Health Direct Bronze 3500 w/Coinsurance*

Eligibility waiting period*

☐ 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

** The period from the date of hire to the date a new employee is eligible to be added to the company health plan*

Please list **ALL** full-time employees working 30 or more hours per week (owners included). You can use additional application forms if you need more room.

Name (first and last)	Date of birth	Plan type*	Covered by spouse	Present carrier/HMO (if applicable)	Current monthly premium
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		
	___/___/___		☐ Yes ☐ No		

** Plan Type: I – Individual; 2P – Two Person; E+C – Employee & Child(ren); F – Family*

(continued)

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Full-time Equivalent Employees

Total number of employees (ACA Definition): Number of full-time and full-time equivalent employees (FTE's), including any PT and seasonal employees who are employedat the time of the policy effective date working 30 or more hours per week. ** _____

** You can use the following link to find out more about the FTE calculation and determine how to perform this calculation for your group: healthcare.gov/shop-calculators-fte. If you have questions regarding these rules or any unique circumstances, please consult with your broker, legal counsel or HSA.

Employer contribution *Minimum of 50% for Individual and 33% for Family*

Individual _____% Family _____%

Within the last 12 months has your company made any late payments for health insurance? ☐ Yes ☐ No

If yes, how many times? _____

Did your company cancel more than 2 health plans in the last 4 years? ☐ Yes ☐ No

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.

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 _____ Phone ___-___-____

City _____ State _____ ZIP _____

For office use only

Account # _____ Effective date ___/___/___ Account representative _____

Approved by _____ Date ___/___/___