New Submission Checklist

To ensure your application is processed as quickly and accurately as possible, follow these steps:

Step	☐
1. Complete and sign your Group Employer Application. Make sure to include your SIC code.	☐
2. Provide a copy of your present insurance carrier's current premium statement.	☐
3. Provide a copy of the following information: **If a sole proprietorship:** • 1040 Schedule C • Wage Detail Report from DUA QUEST System/WR-1 Mass. Quarterly Payroll (if filed) **If a corporation or partnership:** • Wage Detail Report from DUA QUEST System/WR-1 Mass. Quarterly Payroll (most recent) **If a new business:** • Copies of a DBA Certificate, Business License, Articles of Incorporation, or other proof deemed appropriate by HSA	☐
4. Ensure each eligible employee completes and signs an Employee Enrollment Form. Make sure each employee selects a primary care provider (PCP) for themselves and all dependents.	☐
5. Ensure each eligible employee applying for a waiver completes a Waiver of Coverage Form.	☐
6. Enclose a copy of your proposal/quote, showing the rates for your desired plan, and your requested effective date.	☐
7. Pay your first premium: • 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)*	☐
8. Enclose your Annual Membership Fee of $125 (payable to HSA), (see step 8). 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.)*	☐
9. Send your completed Group Membership Application, employee Group Enrollment Forms, and all required documents, including this checklist, to: **HSA Main Office** **135 Wood Road** **Braintree, MA 02184** HSA must receive your complete application and your premium payment at least **five** business days prior to your requested effective date. Coverage will be effective the first day of the following month.	☐

Once HSA approves and processes your application:

- Keep a copy of your application as your temporary ID.
- Watch the mail for your member confirmation with your account number.
- Have your employees look for their permanent ID card(s) from Tufts Health Direct, mailed to each eligible employee within 7 – 10 days from the date HSA approves and processes your application.

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)

Group Membership Application

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 ___ /___ /___

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.

Coverage type (select one)

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

Please provide **ALL** 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

Dependent name (first and last) ______________________________

DOB __/__/__ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name ______________________________ PCP ID # ______________ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ______________________________

DOB __/__/__ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name ______________________________ PCP ID # ______________ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ______________________________

DOB __/__/__ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name ______________________________ PCP ID # ______________ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ______________________________

DOB __/__/__ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name ______________________________ PCP ID # ______________ Existing patient ☐ Yes ☐ No

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 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 Tufts Health Plan 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 Tufts Health Plan 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 __/__/__

Corporate Office
135 Wood Road
Braintree, MA 02184
781.848.4950

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

Corporate Office
135 Wood Road
Braintree, MA 02184
781.848.4950

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.

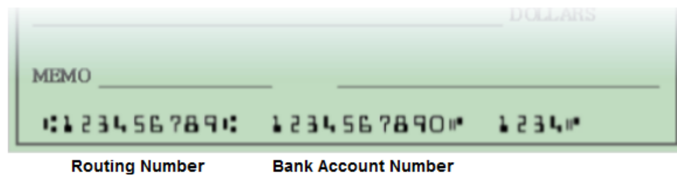
Bank Information:

Bank Name: ______________________ City: __________ State ___ Zip: ______

Name on Account: ____

Routing Number: ________________ Bank Account Number: ________________

Account Type: ☐ Checking ☐ Savings



Routing Number Bank Account Number

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.