MASSACHUSETTS

Account Application Form for Insured Business

Introduction

Thank you for choosing one of our health and/or dental benefit programs.

To ensure that your application is processed without delay, please complete the information requested in Parts 1 and 2. Part 3 will be completed by Blue Cross and Blue Shield. Please complete Part 4 , read Part 5 and sign the completed application where indicated.

Part 1

Introduction

1. Employer's Legal Name

Doing Business As (DBA)

Employer's Business Address (Street, City, Zip Code)

Executive Contact | Title | Telephone | Fax

Email Address

Billing Address (Street, City, Zip Code) ❑Same as Business Address

Billing Contact | Title | Telephone | Fax

Email Address

❑Corporation ❑Partnership ❑Proprietorship ❑Other (Explain Below)

Nature of Business | Employer's Tax ID No.

Human Resources Administrator's Name | Telephone | Fax

Email Address

2. Information about any subsidiaries or affiliates that are a separate legal entity and whose employees are to be included.
Give subsidiary's or affiliate's legal name and business address (Street, City, State, Zip Code)

Telephone

❑Corporation ❑Partnership ❑Proprietorship ❑Other (Explain Below)

Nature of Business | Employer's Tax ID No.

3. Date Company was Established (Month./Year)

4. Does Employment vary seasonally? ❑Yes ❑No If yes, please explain below

Explanation:

5. Please List the name(s) of prior carrier(s)

MEDICAL	DENTAL
1.	1.
2.	2.

Part 2

Account Information

1. Eligible employees are defined as: permanent full-time employees regularly working 30 or more hours per week and permanent part-time employees working at least 20 hours, but less than 30 hours per week, at the employer's usual place of business and paid in accordance with state and federal wage requirements.

2. A. What is the total number of your employees? (Includes full and part-time individual(s) who received payments from the employer that are subject to FICA taxes.) This information is very important to classify your company correctly for Federal Medicare Secondary Payer (MSP) requirements.

B. What is the total number of your permanent employees that are actively working and eligible for health care coverage?

C. Of the employees described in B, what is the total number that you have not enrolled because they are enrolled in another group health plan through their spouses or through other insurance such as Mass Health or Connector plans? (Documentation of other coverage, for each employee, must accompany this application)

Medical	Dental

D. Of the employees described in B, what is the total number you are enrolling in all your health care coverages?

Medical	Dental

E. Of the employees identified in B, what is the total number that have not selected health care coverage? (Do not include those identified in C.)

Medical	Dental

F. What is the total number of other personnel that are not actively working but are eligible for your group health care coverage? (For example: Retirees, COBRA)

Medical	Dental

3. Please indicate the number enrolled in the following categories based on total enrollment in all health insurance plans.

	Full-Time Employees		Part-Time Employees
	Retireees Under 65		Retireees Over 65
	COBRA		Working Aged

4. What is the probationary time period (or waiting period) for employees enrolled after the original effective date of this group?

5. Are domestic partners eligible for coverage? ❑Yes ❑No If yes, please check one:

❑Same sex only ❑Opposite sex only ❑Same and opposite sex

Part 3

Benefit Information

Part 3 to be completed by Blue Cross and Blue Shield

SIC Code

Account Number:

Anniversary Date:

Broker Code:

Agency Code:

Requested Effective Date	Product	Group Type (See Below)	Number of Enrollees	Employee Contribution: Indicate Percent or Fixed Amount. (If other method, please explain below.)			
				Percent ❑		Fixed Amount ❑	
				Individual	2 person	Family	Other

Personal Edge Yes ❑ No ❑ | BlueLinks Yes ❑ No ❑ | Legislative Code:

Account Classifications:

❑ Local Business ❑City/Town ❑ National ❑ Health and Welfare Fund ❑ Student Group

Group Type Codes:

1 Regular	4 Medicare A	7 Retiree Under 65	10 COBRA
2 Working Aged	5 Medicare B	8 Retiree Over 65	11 Other (specify under Product)
3 Medicare A & B	6 Medicare Ineligible	9 Medex	

Part 4

Broker Designation (if applicable)

I hereby authorize _____ (Broker) of _____ (Agency) to obtain and recieve information from Blue Cross and Blue Shield of Massachusetts on _____ (Company Name)'s behalf and to recieve fee and/or commission compensation on the group health insurance plan(s) established by this account application.

This designation is effective _____ (Date) and will remain in effect until rescinded in writing by me or an authorized representative of _____ (Company Name). I certify that I have contract signing authority to designate broker payment.

Name: _____ Title: _____ Date: _____

Part 5

I Understand That:

(1) Coverage is not effective until approved by Blue Cross and Blue Shield.
(2) Final premium rates are subject to current Blue Cross and Blue Shield underwriting guidelines and FINAL ENROLLMENT.
(3) Requested effective date of coverage may be declined or deferred if the information submitted is incomplete.
(4) Existing coverage should not be canceled until this request is approved.
(5) No broker or consultant may make or modify a contract for Blue Cross and Blue Shield.
(6) All enrolled groups are subject to enrollment eligibility reviews at any time.
(7) All groups must verify their enrollment on an annual basis at renewal.
(8) Groups found to have misrepresented eligibility of subscribers(s) are subject to immediate cancellation, with no conversion privileges, and are liable for all benefits paid for inappropriately enrolled subscribers.

I certify that the information in this application is true and complete.

Non-Discrimination under Massachusetts Law

By signing below, I confirm that each Blue Cross and Blue Shield product for Massachusetts residents listed in Part 3 above is being offered by _____(company name) to all full-time employees in Massachusetts and, except as permitted by law, _____(company name) does not contribute a smaller percentage of the premium for lower paid full-time employees than higher paid full-time employees who live in Massachusetts and enroll in the same product. (This non-discrimination provision does not apply to employees covered by collective bargaining agreements).

Signed By (Authorized Employer Representative)	Title	Date

Company Name

Sales Executive	Date	Regional Office	Territory No.	Telephone