WR-1 Form

Date

Name
Company
Street
City/Town/State/Zip

Dear Name:

Thank you for applying for Blue Cross Blue Shield coverage. We appreciate your choosing us as your health care partner!

All group applications are required to have a copy of the Massachusetts Department of Revenue Form WR-1 (Employer's Quarterly Report of Wages Paid) or Form 1-ES (Self-Employed Quarterly Report). However, because we recognize that as a new business, you may not have filed your business tax forms as yet, we will underwrite health coverage for your group under the following condition (provided all other enrollment criteria are met):

Within 90 days of your group's established effective date of coverage, you agree to submit a copy of your WR-1 or 1-ES tax form. The copy may be submitted to:

Blue Cross Blue Shield of Massachusetts
Small Business and Select Markets Quality Assurance
Landmark Center
401 Park Drive, 01/06
Boston, MA 02215-3326

Upon receipt, we will process your application and keep this letter with your current file.

Should we not receive this required tax form within 90 days, your group coverage will be canceled retroactive to its effective date and you will be responsible for all incurred claims.

Please sign, date, and return this letter in the enclosed self-addressed envelope to indicate your agreement with this condition of coverage.

Thank you.

Sincerely, ______________________________

I agree to submit a copy of my initial Massachusetts Department of Revenue Form WR-1 or Form 1-ES (whichever applies) to Blue Cross Blue Shield of Massachusetts, at the address above, within 90 days of my group's established effective date of coverage. I understand that my group coverage will be canceled retroactive to its effective date of coverage and that I will be responsible for all incurred claims if the tax form copy is not received by Blue Cross Blue Shield within 90 days of my group's established effective date of coverage.

____
[Company name]

____
[Print name]

____
[Signature and title] [date]

enclosure

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