HEALTH NEW ENGLAND

One Monarch Place · Suite 1500
Springfield, MA 01144-1500
413-787-4000 · 800-842-4464
hne.com · hnewhizkidz.com

GROUP NUMBER ____________________

EMPLOYER GROUP APPLICATION (PAGE 1)

DIRECTIONS *Please return the following information to:*
Sales Department, Health New England, One Monarch Place, Suite 1500, Springfield, MA 01144
Please include:

❑ Employer Group Application *(both sides)* ❑ Enrollment Forms

❑ Evidence of employment which may include payroll records or WR-1. Please indicate employees who are part time and/or not eligible for coverage and employees who are waiving coverage and employees who have terminated employment. *(Please contact the HNE Sales Department to discuss alternatives.)*

❑ Business check in the amount equal to first month's premium made payable to Health New England

EMPLOYER ACCOUNT INFORMATION

COMPANY NAME	NATURE OF BUSINESS	SIC CODE / TAX ID#

STREET ADDRESS	BILLING ADDRESS (IF DIFFERENT)
PO BOX	BILLING CONTACT
CITY STATE ZIP	CITY STATE ZIP
EXECUTIVE CONTACT	BENEFITS ADMINISTRATOR
PHONE FAX	PHONE FAX
EMAIL ADDRESS	EMAIL ADDRESS

# OF ELIGIBLE EMPLOYEES	# OF EMPLOYEES ENROLLING	RETIREES (AGE 65+ WITH MED A&B)	# OF COBRA ENROLLING	DOMESTIC PARTNER COVERAGE ❑ YES ❑ NO

TOTAL NUMBER OF EMPLOYEES (INCLUDE ALL FULL- AND PART-TIME EXEMPT EMPLOYEES SUBJECT TO FICA TAXES)*: ____________________

* **THIS INFORMATION IS NECESSARY IN ORDER TO CLASSIFY YOUR COMPANY CORRECTLY FOR FEDERAL MEDICARE SECONDARY PAYER (MSP) REQUIREMENTS.**

IMPORTANT: The employer must notify Health New England within five (5) business days of when the total number of employees either increases to 20 or more or drops below 20 during the contract year. HNE will validate the total number of employees at the group's renewal date.

GROUPS FOUND TO HAVE MISREPRESENTED ANY OF THE ABOVE INFORMATION MAY BE SUBJECT TO IMMEDIATE CANCELLATION, WITH NO CONVERSION PRIVILEGES.

EMPLOYER CONTRIBUTION

HNE HAS A MINIMUM REQUIREMENT OF 50% OF SINGLE RATE

COMPANY CONTRIBUTION (PERCENT OF PREMIUM OR DOLLAR AMOUNT CONTRIBUTED TOWARD MONTHLY RATE) ____________________

IF APPLICABLE: EMPLOYER CONTRIBUTION PERCENTAGE CONTRIBUTED TO RETIREE COVERAGE ____________________

EMPLOYER GROUP CERTIFICATION

The foregoing statements are (1) true and correct to the best of my knowledge and belief and (2) made to induce the issuance of health coverage by Health New England (HNE). I understand and agree that any coverage issued shall be subject to the terms of the HNE Employer Agreement. I acknowledge that I have received a copy of the HNE Employer Agreement. I also acknowledge that coverage is not effective until approved by HNE and that the requested effective date may be deferred if the information submitted is incomplete. As required under MGL c. 176G § 6A and as further set forth in the HNE Employer Agreement, I also specifically agree that the group is contracting with HNE to offer benefit plan(s) to all full-time employees who live in Massachusetts, and that the health insurance premium contributions for the benefit plan(s) made by the group are not smaller for full-time employees who earn lower wages, computed hourly or annually, than for other full-time employees who receive an equal or greater total hourly or annual salary.

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SIGNATURE OF COMPANY OFFICIAL	TITLE	DATE

4/8/09 09UW/IKON

HNE PLAN INFORMATION

Requested Effective Date	Anniversary Date	New Hire Waiting Period

Plan Name:	Deductible*	Rate Tier Type	RX Copays:	Chiro Copays:
Plan Name: ____ ____	Deductible* CY ❑ PY ❑	Rate Tier Type Tier 2 ❑ Tier 3 ❑ Other ❑ ____	RX Copays: ____ ____	Chiro Copays: ____ ____
Plan Name: ____ ____	Deductible* CY ❑ PY ❑	Rate Tier Type Tier 2 ❑ Tier 3 ❑ Other ❑ ____	RX Copays: ____ ____	Chiro Copays: ____ ____
Plan Name: ____ ____	Deductible* CY ❑ PY ❑	Rate Tier Type Tier 2 ❑ Tier 3 ❑ Other ❑ ____	RX Copays: ____ ____	Chiro Copays: ____ ____
Plan Name: ____ ____	Deductible* CY ❑ PY ❑	Rate Tier Type Tier 2 ❑ Tier 3 ❑ Other ❑ ____	RX Copays: ____ ____	Chiro Copays: ____ ____

* Please verify with your sales representative which plans offer calendar year or policy year deductibles.

BROKER OF RECORD ASSIGNMENT

The group designates the broker named below as Broker of Record to obtain and receive information from HNE on the group's behalf and to receive commissions which may become payable upon acceptance of this application by HNE.

BROKER NAME ____ COMPANY ____

ADDRESS ____ CITY ____ STATE ____ ZIP ____

FOR INTERNAL USE ONLY

Division Number	BP	Rate	Medical	RX Rider	Chiro	EAP

Broker Assigned by:		Broker SAC Code:	Date:	
# of Eligible Employees	# of Employees Enrolling	Retirees (Age 65+ with Med A&B)	# of COBRA Enrolling	
Approved by:	Date:	Entered by:	Date:	New Business Rep:

4/10/09 09UW/IKON