



38 Chauncy St, Boston, MA 02111
 Phone: 857-263-8242
 Fax: 857-263-8951
 Minutemanhealth.org

EMPLOYER GROUP APPLICATION

DIRECTIONS: Please return the following information to:
 Sales Department, Minuteman Health, 38 Chauncy St. Boston, MA 02111

Please include:

- Employer Group Application Confirmation of Sold Rates Enrollment Forms Employer Agreement
 Evidence of employment, WR-1. (Please contact the Sales Department to discuss alternatives.)

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		
COMPANY WEBSITE					
SUBSIDIARIES OR AFFILIATES TO BE COVERED AND LOCATIONS					
# OF ELIGIBLE EMPLOYEES	# OF FULL TIME EQUIVALENT (FTE) EMPLOYEES	# OF EMPLOYEES ENROLLING	RETIREES (AGE 65+ WITH MED A&B)	# OF COBRA ENROLLING	

REPORTING INFORMATION (ADDITIONAL SPACE NEEDED, ATTACH SEPARATE SHEET)

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.
 **PLEASE USE THE CALCULATOR FROM healthcare.gov TO DETERMINE THE NUMBER OF FULL TIME EQUIVALENT EMPLOYEES (FTE) IN YOUR GROUP.
 LOCATED AT <https://www.healthcare.gov/shop-calculators-fte/>.

PRIOR CARRIER NAME	RATES
--------------------	-------

MINUTEMAN HAS A MINIMUM REQUIREMENT OF 50% OF EMPLOYEE ONLY RATE & 33% OF FAMILY RATE
 EMPLOYER CONTRIBUTION (FIXED DOLLAR OR %)
 EMPLOYEE ONLY RATE _____ EMPLOYEE + SPOUSE _____ EMPLOYEE + CHILD(REN) _____ FAMILY _____

WILL YOUR GROUP ALSO OFFER COVERAGE THROUGH ANOTHER GROUP HEALTH PLAN? YES _____ NO _____
 IF YES, NAME THE OTHER CARRIER(S):

MEDICAL INFORMATION (ADDITIONAL SPACE NEEDED, ATTACH SEPARATE SHEET)

ARE YOU AWARE OF ANY EMPLOYEES AND/OR DEPENDENTS WHO HAVE INCURRED A CLAIM OF MORE THAN \$25,000 IN THE PAST YEAR?
 YES___ NO___ IF YES, PLEASE PROVIDE DETAILS:

ARE YOU AWARE OF ANY EMPLOYEES WHO ARE NOT ACTIVELY AT WORK, DISABLED, OR MEDICALLY CONFINED DUE TO INJURY OR ILLNESS? YES___ NO___ IF YES, PLEASE EXPLAIN THE CONDITION, TREATMENT, AND EXPECTED RETURN TO WORK DATE.

ARE YOU AWARE OF ANY DEPENDENTS WHO ARE DISABLED, OR MEDICALLY CONFINED DUE TO INJURY OR ILLNESS? YES___ NO___
 IF YES, PLEASE PROVIDE DETAILS:

MHI PLAN INFORMATION

REQUESTED EFFECTIVE DATE

ANNIVERSARY DATE

NEW HIRE WAITING PERIOD

PLAN NAME:

PLAN NAME:

PLAN NAME:

PLAN NAME:

POLICY TYPE:

- CALENDAR YEAR
 PLAN YEAR

RATING TIER:

- 2 TIER
 3 TIER
 4 TIER

DOMESTIC PARTNER COVERAGE:

- YES
 NO

EMPLOYER GROUP CERTIFICATION

To the best of my knowledge and belief, the foregoing statements are (1) true and correct and (2) made to induce the issuance of health coverage by Minuteman Health. The group understands that if it has committed fraud or made a misrepresentation of any material fact in conjunction with this application, Minuteman may retroactively cancel coverage. I understand and agree that any coverage issued shall be subject to the terms of the Minuteman Employer Agreement. I acknowledge that I have received a copy of the Employer Agreement. I also acknowledge that coverage is not effective until approved by Minuteman, and that the requested effective date may be deferred if the information submitted is incomplete. No alteration of any written application for insurance, by erasure, insertion or otherwise, shall be made by any person other than me without my written consent, and the making of any such alteration without my consent shall be a misdemeanor.

SIGNATURE OF COMPANY OFFICIAL

TITLE

DATE

BROKER OF RECORD ASSIGNMENT

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

BROKER NAME

COMPANY

ADDRESS

CITY, STATE

ZIP

New Business Sales Rep.