MASSACHUSETTS

ACCOUNT APPLICATION FORM FOR INSURED BUSINESS

Thank you for choosing Blue Cross Blue Shield of Massachusetts. Please complete Parts 1, 2, and 3 (if applicable), and review Part 4. Once completed, return this form to us as soon as possible.

Part 1

Account information

Employer's legal name

Doing business as (DBA)

Employer's business address (street, city, state, ZIP code)

Billing address (street, city, state, ZIP code) ❑ Same as business address

❑ Corporation	❑ Partnership	❑ Proprietorship	❑ Other (explain below)

Nature of business | Employer's tax ID no.

Executive contact | Title | Telephone ( ) | Fax ( )

Email address

Human resources administrator's name | Telephone ( ) | Fax ( )

Email address

Billing contact | Title | Telephone ( ) | Fax ( )

Email address

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 | Telephone ( )

❑ Corporation	❑ Partnership	❑ Proprietorship	❑ Other (explain below)

Nature of business | Employer's tax ID no.

s

Date Company Was Established (Month/Year)

Does employment vary seasonally?
❑ Yes ❑ No If yes, please explain:

List the name(s) of prior carrier(s):

Medical	Dental
s	
s	s
s	s

Part 2

Account information

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.

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 who 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.) .....

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

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.) .....

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
C.		
D.		
E.		
F.		

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

	Full-time employees		Part-time employees
	Retirees under 65		Retirees Over 65
	COBRA		Working Aged

Does employment vary seasonally?

☐ Yes ☐ No If yes, please explain:

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

	Full-time employees		Part-time employees

Are domestic partners eligible for coverage? ☐ Yes ☐ No If yes, select one below.

☐ Same sex only ☐ Same and opposite sex

Part 3

Broker/consultant designation (if applicable)

I hereby authorize _____ (Broker) of _____ (Agency) to receive information from Blue Cross Blue Shield of Massachusetts on _____ (Company name) 's behalf and to receive 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.

Is there a secondary or tertiary broker? ☐ Yes ☐ No

(Continued)

Part 3 (continued)

Broker/consultant designation (if applicable)

Specify the name and percentage share for each broker in the spaces below. All percentages should add up to 100%. (e.g. Broker 1: 50%, Broker 2: 50%)

- Broker 1 name: ss _____ Percentage share: _____%
- Broker 2 name: ss _____ Percentage share: _____%
- Broker 3 name: dd _____ Percentage share: _____%

Part 4

I understand that:

(1) Coverage is not effective until approved by Blue Cross Blue Shield of Massachusetts.
(2) Final pricing is subject to current Blue Cross Blue Shield of Massachusetts 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 Blue Shield of Massachusetts.
(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.
(9) The Premium Account Agreement will be considered accepted and binding when the Account first makes a payment to Blue Cross Blue Shield of Massachusetts.
(10) Premium payment is due on or before the date listed on each invoice. Amounts past due are subject to an interest charge of up to 1.5% per month, as described in your Premium Account Agreement.

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

Signed by (authorized employer representative)	Title	Date

Non-Discrimination under Massachusetts Law

By signing below, I confirm that each Blue Cross Blue Shield of Massachusetts product for Massachusetts residents is being offered by _____
(Company name)
to all full-time employees in Massachusetts and, except as permitted, _____ does not contribute a smaller
(Company name)
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 no.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.
ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

® Registered Marks of the Blue Cross and Blue Shield Association. © 2024 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.