

## Introduction

Thank you for choosing Neighborhood Health Plan.

Please complete the request information in Parts One Two, and Three.

Part Four will be completed by Neighborhood Health Plan.

Please read Parts Five and Six, sign this completed application form and return it to your NHP Sales Account Executive prior to enrollment.

## Part One – Group Information

1 Employer's Legal Name		
_____ Employer's Business Address (Street, City, State, Zip Code)		
Executive Contact	Title	
Executive Contact Phone Number	Executive Contact Email	Executive Contact Fax Number
Billing Address (Street, City, State, Zip Code)		<input type="checkbox"/> Same as Business Address
Billing Contact Name	Title	
Billing Contact Phone Number	Billing Contact E-mail	Billing Contact Fax Number
Nature of Business	Standard Industry Classification (sic) or NAICS (if known)	Employer's Tax ID Number
Employer Web Site		
Does Employment Vary Seasonally? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Explain Below		
2 Information about any subsidiaries or affiliates that are a separate legal entity and whose employees are to be included. Give subsidiary's legal name and business address (Street, city, State, Zip Code) below. Please copy this page if necessary to include additional affiliates.		
Subsidiary Name		
Business Address		Employer's Tax ID Number
Nature of Business		
Does Employment Vary Seasonally? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Explain Below		



**Part Two – Group Enrollment Information**

1. Eligible employee is defined as permanent full-time regularly working 30 or more hours per week and permanent part-time employees working at least 20 hours per week, the majority whom work in Massachusetts.

a. Do you plan on enrolling employees other than those described above?

 Yes

 No

If yes, please explain:

b. Do you exclude employees from coverage?

 Yes

 No

If yes, please explain:

2.

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

B. Of the employees described in A, what is the total number that you have not enrolled because they are enrolled in another group health plan through their spouses or because they have voluntarily waived coverage? (Health Coverage Waiver Forms for each employee identified in b. must accompany this application)

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

3. What is the probationary time period (waiting period) in months for employees before they become eligible for health coverage?

Full-Time Employees

Part-Time Employees

**Part Three – Other Insurance Information**
**A. Workers Compensation Carrier:**

Workers Compensation Carrier Name

Phone Number

Policy Effective Date

**B. Other Health Insurance Carriers:**

Name / Anniversary date	Monthly Premium	Copayments			Deductible (list amount or none)	Group Type (see below)	Number of Enrollees	Employer's Contribution: Indicate Percent or Fixed Amount (if other method, please explain below)		
		Office	ER	Rx				Percent <input type="checkbox"/> Fixed Amount <input type="checkbox"/>		
								Individual	Family	Other

Group Type Codes: 1 Regular 2 COBRA 3 Retiree Under 65 4 Other

**Part Four – Benefit Information (to be completed by Neighborhood Health Plan)**

SIC Code

Rate Effective Date

Month	Day	Year
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 New Business (no current NHP health plan)

 New Group (adding group to existing NHP account)

List New group and existing group information below.

Group Number	Requested Effective Date	Product	Group Type (see below)	Number of Enrollees	Employer's Contribution: Indicate Percent or Fixed Amount (if other method, please explain below)		
					Percent <input type="checkbox"/> Fixed Amount <input type="checkbox"/>		
					Individual	Family	Other

Group Type Codes: 1 Regular 2 COBRA 3 Retiree Under 65 4 Other



**Part Five – Broker Designation**

I hereby authorize \_\_\_\_\_ of \_\_\_\_\_ to obtain and receive information from  
Name of individual broker Name of agency with whom broker is affiliated, if applicable

Neighborhood Health Plan on \_\_\_\_\_ 's behalf and to receive fee and/or commission compensation on  
account name

the group health insurance plan (s) established by this group application. This designation is effective \_\_\_\_\_ and will remain in  
effect until rescinded in writing by me or an authorized representative of \_\_\_\_\_  
account name

I certify that I have contract signing authority to designate broker payment.

Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**Part Six – I Understand That . . .**

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

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

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Signed By (Authorized Employer Representative) \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

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Company Name \_\_\_\_\_

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Sales Representative \_\_\_\_\_ Date \_\_\_\_\_