GROUP INFORMATION FORM

Harvard Pilgrim Health Care

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

COMPANY NAME AND LOCATION

Full Legal Name of Group_____

Other "DBA" or Alias Names:_____

Corporate Headquarters Address _____

City_____State_____Zip_____

Mailing Address(if different) _____

Billing Address (if different)_____

Company Telephone Number_____

EMPLOYER GROUP CONTACT INFORMATION

	Name	Telephone Number	Email Address
Executive			
Benefits Administrator			
Billing			
Employer Portal Contact			
Employer Mailing			
Broker			

COMPANY INFORMATION

Date Business Established_____SIC Code_____Tax I.D. Number_____

Is this Group a ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ LLC Other_____

Is the Group a subsidiary or branch of a corporate parent; or is the Group eligible to file a combined state tax return with another legal entity? ☐ Yes ☐ No

If yes, what is the total number of employees in all locations (being either subsidiaries or branches of the corporate parent; or entities eligible to file a joint state return)?_____

List the name and address of all physical locations (being either subsidiaries or branches of the corporate parent):

_____

_____

The information below is required for Medicare Secondary Payor (MSP) reporting:

The total number of current employees who receive wages, tips, or other compensation (refer to line 1 of your most recent federal tax return form 941 or 944_____(includes FT, PT, seasonal, new hire): as of this date_____.

Total Full Time Equivalents (FTE)*:_____

Other Eligibility Requirements

*The Group must employ at least one Full-Time Equivalent (FTE) in MA and NH and 1 Eligible Employee in ME who works a minimum of 30 hours per week, that is not an owner and/or spouse of an owner. If you have questions regarding these rules or any unique circumstances, please consult with your benefits advisor or legal counsel.

Number of full-time employees_____Number of part-time employees_____Number of seasonal employees _____

How many were employed 12 months ago?_____How many employees are eligible for health insurance? _____

Employees covered under a collective bargaining agreement are ☐ Included ☐ Excluded ☐ Not Applicable

Do you regularly employ at least one individual that is not an owner and/or spouse of an owner? ☐ Yes ☐ No

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HEALTH PLAN INFORMATION

Effective Date: _____

Plan #1 Type: ☐ HMO ☐ PPO ☐ POS Plan #1 Name: _____

Plan #2 Type: ☐ HMO ☐ PPO ☐ POS Plan #2 Name: _____

Plan #3 Type: ☐ HMO ☐ PPO ☐ POS Plan #3 Name: _____

Group coverage for Domestic Partnerships:

☐ Not Covered ☐ Same & Opposite Sex ☐ Opposite Sex Only ☐ Same Sex Only

The waiting period:

☐ Date of hire

☐ 1st of the month following date of hire ☐ 30 days following date of hire

☐ 1st of the month following 30 days ☐ 60 days following date of hire

☐ 1st of the month following 60 days ☐ 90 days following date of hire

On the original effective date do you wish to waive the waiting period for all eligible employees? ☐ Yes ☐ No

Employer Contribution (%) **(Not required for small groups sold in NH, ME)**

EE_____% EE /SP_____% EE /CH (ren)_____% Family_____%

NOTE: Harvard Pilgrim Health Care requires minimum of 50% employer contribution toward individual coverage, 33% toward EE/SP, EE/CH, EE/CH (ren) and family monthly premiums. These conditions do not apply to applications submitted during the limited enrollment period established by 45 CFR 147.104(b)(1).

Will the Group also offer coverage through another group health plan? _____

If yes, name and renewal date of other carrier(s) _____

Are any former employees or dependents continuing coverage under a provision of COBRA or any state continuation of coverage? If yes, please list each person below.

Name	Type of Continuation	Reason for Continuation	Start Date of Continuation	End Date of Continuation

Has the Group ever offered Tufts Health Plan or Harvard Pilgrim Health Care before? ☐ Yes ☐ No

If yes, from_____to_____ Reason for leaving _____

Was the Group covered under a different legal name other than what is listed in Company Name Section? ☐ Yes ☐ No

If yes, please indicate the legal name _____

PRIOR INSURER PLAN INFORMATION

Does the Group have an existing health plan(s)? ☐ Yes ☐ No

If yes, current carrier(s) _____

Is the Group's existing health plan(s) through a PEO? Yes ☐ No ☐

If yes, MA groups must submit a termination letter from PEO stating Group is terminating their entire PEO relationship with them.

GROUP INFORMATION FORM

REPRESENTATION AND WARRANTY

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. Further, the Group acknowledges that its coverage will become effective only upon Harvard Pilgrim Health Care's written acceptance of this application and payment by Group of the required premium at rates determined by Harvard Pilgrim Health Care. The Group also acknowledges that if the Group commits fraud or misrepresents matters related to this application, Harvard Pilgrim Health Care has the authority to retroactively terminate coverage back to the date of the fraud or misrepresentation. In Maine, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits. Please note, acceptance of this application is subject to applicable law and Harvard Pilgrim Health Care's policies and underwriting guidelines. If Harvard Pilgrim Health Care accepts this application, the Employer Group Agreement will become effective on the latter of the effective dates requested or on the date the required number of employees have enrolled, whichever is later. This Group agrees to notify Harvard Pilgrim Health Care promptly of any changes to this information.