Mass General Brigham
Health Plan

Group Application Form

Thank you for choosing Mass General Brigham Health Plan. Please complete all required information, sign this form, and return it to your Sales Executive no later than 5 business days prior to the effective date.

Employer Name: _____

Other "DBA" or Alias Name(s): _____

Company Address

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Billing Address (if different from above)

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Information

Executive: _____ _____ _____
NAME PHONE EMAIL

Billing: _____ _____ _____
NAME PHONE EMAIL

Administrator: _____ _____ _____
NAME PHONE EMAIL

Company Information

Tax ID: _____

SIC Code: _____

Date company established: _____

☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other (explain) _____

Are any subsidiaries or affiliates to be covered? ☐ yes ☐ no

If yes, name of subsidiary or affiliate and address:

_____

Total # of employees: _____ # of part time: _____ # of full time: _____

Total # of eligible employees: _____ # of full-time equivalent (FTE) _____

# of COBRA employees: _____ # working aged _____

retirees over 65 _____ # retirees under 65 _____

Employer Contribution Amounts

Notes:

1. *Minimum requirement is 50% for individual and 33% for all other tiers*
2. *For Merged Market groups, amounts must be included for all four tiers.*

Individual: _____

Employee/Spouse: _____

Employee/Children: _____

Family: _____

New Hire Waiting Period (not to exceed 90 days): _____

Minimum Hours per Week Required for Insurance Eligibility: _____

Domestic Partner Coverage (please select one option only)

☐ None ☐ Same and opposite sex ☐ Opposite sex only ☐ Same sex only

PLAN COVERAGE

Requested effective date: _____ If prior coverage, anniversary date: _____

Please list prior carrier(s): _____

Will you also offer coverage through another group health plan? ☐ yes ☐ no

If yes, name of other carrier: _____

Mass General Brigham Health Plan Selected Plans

Merged Market accounts may offer up to three plan designs. Large Group accounts may offer up to five plan designs.

Plan 1 Type: ☐ HMO ☐ PPO

Plan 1 Name: _____ # enrolling: _____

Plan 2 Type: ☐ HMO ☐ PPO

Plan 2 Name: _____ # enrolling: _____

Plan 3 Type: ☐ HMO ☐ PPO

Plan 3 Name: _____ # enrolling: _____

Plan 4 Type: ☐ HMO ☐ PPO

Plan 4 Name: _____ # enrolling: _____

Plan 5 Type: ☐ HMO ☐ PPO

Plan 5 Name: _____ # enrolling: _____

Health Reimbursement Account/Participating Funding Arrangement (if applicable)

Administrator: _____

Amount Funded: $_____ or _____ %

BROKER DESIGNATION (if applicable)

I hereby authorize_____of_____to obtain,
NAME OF BROKER BROKERAGE AGENCY

receive information and to act on matters regarding group eligibility from Mass General Brigham Health Plan

on behalf of _____and to receive fee and/or commission compensation on the group
EMPLOYER NAME

health insurance plan(s) established by this application. This designation is effective_____and will
EFFECTIVE DATE

remain in effect until rescinded in writing by an authorized representative of _____.
EMPLOYER NAME

I understand that…

1. Coverage is not effective until approved by Mass General Brigham 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 Mass General Brigham Health Plan.
5. Final premium rates are subject to current Mass General Brigham 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.

Signature: _____ Date: _____

AUTHORIZED EMPLOYER REPRESENTATIVE

Print name: _____ Title: _____

Employer group: _____

Broker signature: _____ Date: _____

Brokerage agency: _____