



Harvard Pilgrim Health Care Intermediary Group Application



Business Information

Legal Business Name _____

Name of Owner/Principal Contact _____

Business Address _____

Mailing Address (if different from Business Address) _____

Business Telephone _____ Business Fax _____

Business E-Mail Address _____ Employer's Tax ID # _____

Years in Business _____ Business Description and SIC (please include below) _____

Insurance Selected

HPHC Plan Selected	Drug (Y/N)	Effective Date Requested

Anniversary Date for Intermediary Contracts is April 1st

Employee Information

Total Number of Eligible Part-time & Full-time Employees (PTEs & FTEs)¹ _____

Are Part-time Employees Eligible for Health Benefits (Y/N)? _____

Number of Part-time Employees? _____

Number of Part-time Waivers? _____

Number of Waivers (excluding PTE) for the Following Reasons:

- FTE is covered under another plan as spouse or dependent _____
- FTE is covered by MassHealth, Medicare or Veterans programs _____
- FTE is covered under another plan sponsored by a second employer _____
- FTE is covered by a non-group plan _____
- FTE is out of HPHC's enrollment area _____

Number of People Declining to Participate in Health Care Benefits at this Time _____

Number of People Enrolling in this Plan Under COBRA _____

Total Number of People Enrolling in this Plan ² _____

1. PTEs must work a minimum 20 hours per week; FTEs must work a minimum of 30 hours per week to be eligible.
This total includes working owners and excludes COBRA enrollments.

2. HPHC requires 100% participation from groups with 1 - 5 employees and 75% participation from groups 6+.
Final Premium Rates are based on actual enrollment forms received.

Does your company have a waiting period before New Hires are eligible for benefits (Y/N)? _____

What is the length of time for the wait? _____ Is the wait waived for initial enrollment? _____

Employer Contribution Policy

Employer Contribution towards all Individual Contracts

Employer Contribution towards all Family Contracts

HPHC requires minimum employer contributions of 50% towards the individual and 33% towards the family contracts.

Insurance History

Do you currently have insurance? If Yes, with whom? _____

Has your company canceled more than 3 health plans in the last four years? _____

Authorization

I understand and agree that any coverage issued shall be subject to the terms of applicable employer agreement for the product purchased, receipt of which is hereby acknowledged.

SIGNATURE OF COMPANY OFFICIAL _____	TITLE _____	DATE _____
SIGNATURE OF BROKER _____	TITLE _____	DATE _____