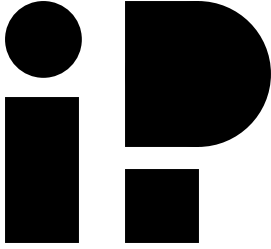


# EMPLOYER APPLICATION



**Insurance Partnership**  
From the Commonwealth of Massachusetts

**Please Mail to:**  
**Insurance Partnership**  
**354B Turnpike Street, #204**  
**Canton, MA 02021**

**Employers Please Include:**

Copy of Quarterly Wage & Tax Statement (WR-1)  
Copy of **Previous** Months Health Insurance Bill  
Broker/Agent Name (If Applicable): \_\_\_\_\_

**REASON FOR APPLICATION**

PLEASE CHECK ONE:  
NEW APPLICATION:                      REVISED INFORMATION:                      REQUESTED EFFECTIVE DATE FOR APPLICATION/REVISIONS:  
Date: \_\_\_\_\_ / \_\_\_\_\_ (MM/YY)

**COMPANY INFORMATION**

LEGAL NAME OF FIRM		CORPORATION <input type="checkbox"/> PARTNERSHIP PROPRIETORSHIP	FEDERAL TAX ID NUMBER (FEIN):
CONTACT NAME & TITLE	COMPANY NAME TO APPEAR ON STATEMENT		TYPE OF BUSINESS  <b>SIC CODE:</b>
ADDRESS	CITY	STATE	ZIP CODE+4
NATURE OF BUSINESS			BUSINESS START DATE (mm/yyyy)
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE+4
TELEPHONE	FACSIMILE		E-MAIL ADDRESS
PLEASE LIST ANY ADDITIONAL COMPANY NAMES (DBA'S)		NO. OF FULL-TIME EMPLOYEES:	EST. NO. ELIGIBLE FOR THE INSURANCE PARTNERSHIP:

**INSURANCE INFORMATION**

HEALTH INSURANCE COMPANY:	HEALTH PLAN INFORMATION: DEDUCTIBLE (IF ANY): \$ _____ DOCTOR VISIT COPAY: \$ _____	GROUP INSURANCE NUMBER:	POLICY RENEWAL DATE: (yyyy-mm-dd)
PLAN NAME:			

**COMPANY PREMIUM AND CONTRIBUTION INFORMATION\***

PLAN COVERAGE:	CURRENT MONTHLY PREMIUM:	EMPLOYER CONTRIBUTION %:	EMPLOYER CONTRIBUTION \$:	IF ANY ADDITIONAL EMPLOYEE CLASSES PLEASE LIST:
EMPLOYEE ONLY				CLASS      CONTRIBUTION%
EMPLOYEE AND CHILD(REN)				CLASS      CONTRIBUTION%
EMPLOYEE AND SPOUSE				CLASS      CONTRIBUTION%
EMPLOYEE AND FAMILY				CLASS      CONTRIBUTION%

Date company began contributing at least 50%: \_\_\_\_\_ / \_\_\_\_\_ (MM/YY)

**\*PLEASE NOTE THAT EMPLOYEES ARE NOT ELIGIBLE IF THE EMPLOYER CONTRIBUTION IS LESS THAN 50%**

**IF YOUR COMPANY SPONSORS MORE THAN ONE HEALTH PLAN, PLEASE COPY & FILL OUT THE PREVIOUS SECTION AGAIN FOR THE ADDITIONAL INSURANCE PLAN(S)**

**PAYMENT AUTHORIZATION - (Please Check Box to Accept)**

I hereby authorize Insurance Partnership's or it's administrative agent to deposit and adjust the Insurance Partnership and Premium Assistance Payments in my account. I agree to hold harmless the Insurance Partnership, or its administrative agent, for any disputes or damages arising from over/underpayments made to my account.

Attach Voided Check Here	INITIAL HERE TO AUTHORIZE PAYMENT:  _____
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**EMPLOYER RULES AND RESPONSIBILITIES**

By signing below, the employer agrees to do all of the following:

- Treat all employee data received from the Commonwealth confidentially and in accordance with the requirements of the Fair Information Practices Act (M.G.L. c. 66A), whether or not the person is still an employee or the employer is participating in the Insurance Partnership.
- Report any changes to any information requested on this form to its Insurance Partnership administrative entity within 10 business days of the change.
- Agree to adjust any qualified employee's payroll withholdings related to health insurance coverage by the amount of premium assistance payments issued by the Division, as soon as possible, but no later than 30 days after notification of the premium assistance amount.
- Submit monthly health insurance premiums by the due date of the premium bill.
- Resolve overpayments and underpayments as directed by the Division and/or the appropriate Insurance Partnership administrative entity.

If determined eligible for the Insurance Partnership, \_\_\_\_\_  
(BUSINESS NAME)

Will comply with all rules listed above and with the provisions of the Division's regulations governing participation in the Insurance Partnership, found at 130 CMR 650.000. (A copy of the regulations will be provided by the Insurance Partnership administrative entity from which you received this application.) I understand that my business may be terminated from the Insurance Partnership if it fails to follow any of the above rules or the regulations at 130 CMR 650.000. I further understand that my business's termination from the Insurance Partnership may also result in the termination of premium assistance for my employees.

I certify under penalty of perjury that the information provided on this application is correct and complete to the best of my knowledge.

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AUTHORIZED SIGNATURE	PRINT NAME	TITLE	DATE / /
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