Fallon Health Employer Application—Large Group

INITIAL PAYMENT REQUIRED (CHECK ONE):

☐ CHECK ENCLOSED

☐ ELECTRONIC PAYMENT FORM (ONE-TIME)

☐ ELECTRONIC PAYMENT FORM (RECURRING – ACH FORM ATTACHED)

COMPANY INFORMATION

COMPANY NAME	TAX ID:	SIC CODE

COMPANY ADDRESS

CITY	STATE	ZIP CODE

PHONE	FAX	WEBSITE

BILLING ADDRESS (☐ SAME AS ABOVE)

CITY	STATE	ZIP CODE

IS THE GROUP A:

☐ CORPORATION ☐ PARTNERSHIP ☐ SOLE PROPRIETORSHIP ☐ OTHER (please specify)_____

SUBSIDIARIES OR AFFILIATES TO BE COVERED AND LOCATIONS

TOTAL EMPLOYEES AS OF TODAY	TOTAL FULL-TIME ELIGIBLE EMPLOYEES	TOTAL FULL-TIME EQUIVALENTS (FTES)	TOTAL BENEFIT ELIGIBLES	TOTAL EMPLOYEES AS OF 12 MONTHS AGO

HEALTH PLAN INFORMATION

EFFECTIVE DATE: CHECK ONE:

☐ PLAN YEAR BENEFITS ☐ CALENDAR YEAR BENEFITS

ANNIVERSARY DATE (PLEASE CHECK ONE):

☐ 1ST OF THE MONTH ☐ 15TH OF THE MONTH

ARE DOMESTIC PARTNERS COVERED? ☐ YES ☐ NO

WAITING PERIOD (CANNOT EXCEED 90 CALENDAR DAYS)

CONTACT INFORMATION *(Individuals must be the identified company contacts with authority to discuss rates and benefits)*

EXECUTIVE/OWNER	TITLE
EMAIL	
BILLING CONTACT	TITLE
EMAIL	
BENEFITS ADMINISTRATOR	TITLE
EMAIL	
OTHER OFFICE CONTACT	TITLE
EMAIL	

Illegible and incomplete information will delay enrollment

REPORTING INFORMATION

THE INFORMATION BELOW IS REQUIRED FOR MEDICARE SECONDARY PAYER (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 _____(MM/DD/YY)

WILL YOU BE OFFERING A HEALTH REIMBURSEMENT ARRANGEMENT (HRA), FLEXIBLE SPENDING ACCOUNT (FSA), OR HEALTH SAVINGS ACCOUNT (HSA)?

CHECK ALL THAT APPLY: ☐ HRA ☐ FSA ☐ HSA ☐ NONE

IF YES, HOW MUCH DO YOU, AS THE EMPLOYER, PLAN TO CONTRIBUTE ANNUALLY? $_____ OR %_____

WHO WILL BE THE THIRD PARTY ADMINISTRATOR? ☐ ULTRABENEFITS ☐ OTHER (PLEASE SPECIFY)_____

PRIOR CARRIER NAME	RATES

EMPLOYER CONTRIBUTION (%)

EMPLOYEE_____ TWO PERSON_____ PARENT/CHILD_____ FAMILY_____ OTHER_____

WILL YOUR GROUP ALSO OFFER COVERAGE THROUGH ANOTHER GROUP HEALTH PLAN? ☐ YES ☐ NO

IF YES, NAME OF THE OTHER CARRIER(S):

MEDICAL INFORMATION

ARE YOU AWARE OF ANY EMPLOYEES AND/OR DEPENDENTS WHO HAVE INCURRED MEDICAL COSTS OF MORE THAN $25,000.00 IN THE PAST YEAR?

☐ YES ☐ NO IF YES, PLEASE PROVIDE DETAILS:

ARE YOU AWARE OF ANY EMPLOYEES THAT ARE NOT ACTIVELY AT WORK, DISABLED, OR MEDICALLY CONFINED DUE TO INJURY AND ILLNESS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN THE CONDITION, TREATMENT, AND EXPECTED RETURN TO WORK DATE:

ARE YOU AWARE OF ANY DEPENDENTS THAT ARE DISABLED, OR MEDICALLY CONFINED DUE TO INJURY OR ILLNESS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

BROKER INFORMATION

FALLON HEALTH REQUIRES BROKERS TO FULLY DISCLOSE TO THEIR CURRENT AND PROSPECTIVE CLIENTS ALL COMMISSIONS AND FEES PAYABLE TO THE BROKER BY FALLON IN CONNECTION WITH THE SALE OF PROPOSED GROUP INSURANCE COVERAGE(S) AND SERVICES.

PRIMARY BROKER NAME	BROKER AGENCY ☐ ONLINE ENROLLMENT
SECONDARY BROKER NAME	SECONDARY BROKER AGENCY ☐ ONLINE ENROLLMENT
COMMISSION SPLIT (IF APPLICABLE) ☐ 50/50 ☐ 70/30 ☐ 60/40 ☐ 80/20	COMMISSION TYPE ☐ STANDARD ☐ NON-STANDARD %_____

SIGNATURES

EMPLOYER ORGANIZATION CONTACT NAME/TITLE (PLEASE PRINT):	INDIVIDUAL'S AUTHORIZING SIGNATURE	DATE:
FALLON HEALTH EXECUTIVE SIGNING FOR EMPLOYER ORGANIZATION/TITLE (PLEASE PRINT):	INDIVIDUAL'S AUTHORIZING SIGNATURE	DATE:

Fallon Health Group Service Agreement

WHEREAS the Fallon Community Health Plan, Inc. (FCHP; the Plan), a nonprofit health maintenance organization licensed under Massachusetts General Laws, Chapter 176G, and federally qualified under Public Law 93-222, provides health maintenance coverage for its members; and its subsidiary Fallon Health & Life Assurance Company (FHLAC; the Company. Collectively with FCHP, Fallon), licensed as an insurance company under Massachusetts General Laws, Section 175, provides coverage for health insurance benefits for its insureds, and

WHEREAS the Employer wishes to make available to its employees health maintenance coverage as authorized by Massachusetts General Laws, Section 176G and Public Law 93-222 through the Plan and/or health insurance coverage as authorized by Massachusetts General Laws, Section 175 through the Company.

THEREFORE, by execution of this Group Service Agreement (the Agreement), the Plan, the Company and the Employer agree:

Availability of coverage. That the Employer shall make available to its eligible employees health maintenance coverage through the Plan and/or health insurance coverage through the Company.

Eligibility for membership. That eligibility for membership is the same for Fallon as for any existing health benefits program offered by the Employer, unless otherwise mutually agreed upon. Fallon's eligibility guidelines are outlined in the *Administrative Handbook*. Employees must live or work within the service area applicable to the product in which they are enrolling.

Enrollment opportunity. That any enrollment opportunity is the same for Fallon as for any other health benefits program offered by the Employer.

Anniversary date. That the anniversary date, which is the annual date by which employees may choose to change to another health insurance option, shall be the same for Fallon as for any other health benefits program offered by the Employer.

Employer contributions. The Employer must contribute the same amount toward the cost of Fallon membership as it does toward the cost of other health benefits options offered to its employees, not to exceed Fallon's premium. Except as hereafter provided, the group contribution set forth in the premium rate schedule shall not be changed during the term of the Agreement unless such change is agreed to in writing by Fallon. If, however, the Employer's contribution to such other coverage as may be available through the Employer is increased during the term of the Agreement, then the Employer agrees to increase its contribution to the Fallon coverage by an equivalent amount, effective the first Premium Due Date following such an increase.

Nondiscriminatory offer/equal contribution. That the Employer will comply with Massachusetts General Laws, Chapter 176G Section 6A and Chapter 175 Section 110(O), as clarified by Massachusetts Division of Insurance Bulletin 2007-04. M.G.L. Chapter 176G Section 6A and Chapter 175 Section 110(O) prohibit the sale of fully insured coverage to an employer who offers coverage to its employees in a manner that 1) has the general effect of making coverage options available to higher-paid full-time employees that are not available to lower-paid full-time employees, and/or 2) has the general effect of providing a higher contribution level to higher-paid full-time employees than to lower-paid full-time employees.

Distribution of materials. That the Employer shall receive benefits materials from Fallon and make them available to each eligible employee prior to any enrollment period.

Annual enrollment period. That the Employer shall provide to its employees an annual re-enrollment period of sufficient length and conducted in a manner so as to meet Fallon requirements. During this time, eligible employees may transfer their membership from any existing health benefits program to Fallon or from Fallon to any existing health benefits program offered by the Employer.

Changes in benefits. That Fallon shall notify the Employer at least 60 days prior to any changes in benefits affecting the coverage for its employees unless mandated by law for less than a 60-day implementation. The Employer will notify members/insureds of any benefits changes.

Submission of reports. That monthly remittances, remittance reports, membership applications, change notices and any other transactions required to properly administer the Fallon plan shall be submitted in accordance with the timetable and procedures established by Fallon (generally a period of 30 days from a qualifying event).

Premium payments. That the Employer shall remit to Fallon when due all premium amounts for its employees covered by Fallon, whether or not Fallon services were rendered to these employees. Fallon has the right to cancel this Agreement and coverage to the Employer and its employees for non-payment of such premium amounts in accordance with Fallon's administrative guidelines. Any outstanding balances remaining due after the Fallon plan is no longer offered to the Employer remain a liability of the Employer to Fallon. If the Employer has a broker of record, the broker may be eligible to receive a commission and/or bonus based on the amount of premium paid; Fallon will make specific commission information available on request. Employer agrees that Fallon may disclose to its broker of record member information for the purpose of assisting the Employer with its enrollment and/or disenrollment activities.

Entire agreement. That the contract between the Plan, the Company and the Employer shall include the provisions set forth in this Agreement; the premium rates charged by Fallon for the benefits in effect for the Employer; Fallon's underwriting guidelines; Fallon's *Member Handbook/Evidence of Coverage* for the benefits in effect for the Employer; Fallon's *Administrative Handbook*; any membership transaction forms submitted to Fallon by the Employer on behalf of its employees; and any additional contractual arrangements or amendments to the above (together, "the Contract"). The Employer agrees the *Member Handbook/Evidence of Coverage* and *Administrative Handbook* were received at the time of signing this Agreement. Fallon reserves the right to amend its underwriting guidelines, its *Member Handbook/Evidence of Coverage*, its *Administrative Handbook* and its benefit interpretations without prior notice to the Employer.

Amendment. This Agreement may be amended by agreement of the President or duly designated officer of Fallon, and the Employer, and that any amendments shall become part of this Agreement. Notwithstanding the foregoing, no agent of Fallon has the authority to change this Agreement, waive any of its provisions or restrictions, or extend the time for making payment.

Effect of execution. That, upon execution of this Agreement, all previous Group Service Agreements between the Plan, the Company and the Employer relating to the offering of an FCHP HMO or FHLAC/Fallon Preferred Care PPO and any amendments thereto shall become null and void.

Underwriting guidelines. That the Employer will follow all Fallon underwriting guidelines, including those related to employee hours worked and employer contributions.

Waiting periods. That the Employer will not impose any waiting period on new employees of greater than 90 days, or as otherwise allowed under federal regulations. (45 CFR 147.116).

Fallon access to records. That the Employer agrees to allow Fallon reasonable access to its payroll or other records so that Fallon may audit and verify any enrollee's eligibility for Fallon coverage. Failure to comply with this provision may result in Fallon's termination of this Agreement as of a date they determine to be appropriate.

Fraud/misrepresentation. That if Fallon determines that fraud or misrepresentation has occurred on any of the forms, remittances, membership applications or any other transactions submitted by the Employer to Fallon, Fallon may terminate this Agreement retroactive to the date of the fraud or misrepresentation or as of the most recent group anniversary date or as of the next group anniversary date, at its sole discretion. The Employer will be responsible for reimbursing Fallon for the difference between any premium paid by the Employer and any medical care costs paid by Fallon from the point of the fraud or misrepresentation to the termination date.

Workers' compensation. That the Employer, if eligible to carry a Workers' Compensation policy, will maintain such a policy in effect with this Group Service Agreement. Fallon may terminate this Agreement as of the earlier of the date the Workers' Compensation policy is terminated or the Employer's most recent group anniversary, at its discretion.

Termination. That Fallon reserves the right to terminate this Agreement if premium payments are not received on time or within any applicable grace period; upon written notice, if there is no longer any covered enrollee who lives or works in Fallon's service area; if group membership is offered through an association and the employer's membership ceases; if Fallon ceases to offer coverage in the market, provided that all applicable notice and other provisions shall be complied with; if the employer does not have a Massachusetts business location; or in the event of a material breach of the Agreement (with right to cure prior to the effectiveness of the termination).

That the Employer reserves the right to terminate the Agreement in the event of insolvency or bankruptcy of Fallon; in the event of the revocation of Fallon's licensure; or, in the event of a material breach of the Agreement (with right to cure prior to effectiveness of the termination). Should it be necessary for the Employer to terminate the contract due to extenuating circumstances outside the above, the Employer shall make every effort to give at least 30 days written notice to Fallon.

Applicable law. That the Agreement shall be governed by the laws of the Commonwealth of Massachusetts, as applicable. That both parties are required to comply with and maintain security measures outlined in Code of Massachusetts Regulations, 201 CMR 17.00, to protect personal information as defined therein. That both parties will comply with all applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Advertising policy. That the Employer shall not use the name or likeness of Fallon in any document or in any communication for any purpose, including, without limitation, advertising, promotional events, employee information collection or identification, or similar uses without the expressed written consent of Fallon. This includes, but is not limited to, newsprint or other printed media, television, radio, computer or other electronic communication methods.

Effective date. That this agreement between the Plan, the Company and the Employer shall become effective as of the date shown on the front of this form and shall be effective to the Employer's next anniversary date and from year to year thereafter, unless terminated by either party by written notice. Each party will make every effort to give at least 60 days notice prior to the anniversary date.

Employer Tools Enrollment Form

If you are an employer that offers Fallon Health (Fallon) and you would like secure access to Employer Tools on fallonhealth.org, please fill out the form below. Upon receipt and review by Fallon, the name of the directory where files can be dropped off and picked up, your username and password will be forwarded to the authorized individual listed as the contact. If you do not hear back from us **within 15 business days**, please call 1-800-333-2535, option 6 to confirm receipt.

EMPLOYER INFORMATION

LEGAL NAME OF EMPLOYER ORGANIZATION (PLEASE PRINT):		CUSTOMER NUMBER:
EMPLOYER CONTACT NAME (PLEASE PRINT)	PHONE:	E-MAIL:
EMPLOYER IT CONTACT NAME (PLEASE PRINT)	PHONE:	E-MAIL:

EMPLOYER TOOLS USER AUTHORIZATION

I authorize the following employees access to Employer Tools and electronic data submission through fallonhealth.org. For third party agencies to have access to Employer Tools, please complete the Billing Agency/Broker Authorization Form located on the following page in addition to this form.

EMPLOYER NAME	EMPLOYEE EMAIL ADDRESS	EMPLOYER TOOLS		
		ONLINE ENROLLMENT TOOL	DROP OFF ELIGIBILITY FILE* (i.e. 834/FTP Access)	PICK UP ELECTRONIC REPORTS* (i.e. 999/FTP Access)
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

*Must have 50 members for these options

AGREEMENT TERMS

I will protect all usernames and passwords given to me during this registration process from unauthorized use and disclosure. I understand that I am responsible for all actions performed while accessing Employer Tools. I will notify Fallon Health (Fallon) immediately by calling Fallon at 1-800-333-2535, option 6, if I believe a password has been compromised. I will notify Fallon to disable access when an employee's responsibilities no longer require using Employer Tools, or when an employee terminates.

I understand that as an employer, I am responsible for compliance with all federal and state requirements regarding the confidentiality of health care information and that I have responsibility for the actions and use of that information for those users for whom I have designated access. The undersigned agrees to indemnify and hold harmless Fallon for any breach of this confidentiality agreement and shall be liable to Fallon for any such breach of this agreement and damages resulting from such breach, including but not limited to, interference and contractual relations, interference with advantageous relations, loss of any contract and any other losses and/or damages together with Fallon's expenses in connection with the breach, including but not limited to costs, accountant fees, consultant fees and reasonable attorney's fees.

I authorize Fallon to receive and process eligibility electronically in accordance with applicable regulations. I assure that all information submitted is accurate and any eligibility submitted in falsification is prosecutable under state and/or federal laws.

All information provided on the Fallon website is accurate to the best of our knowledge. Fallon shall not be liable for any claims, loss or damage resulting from its use.

SIGNATURES

INDIVIDUAL SIGNING FOR EMPLOYER ORGANIZATION/TITLE (PLEASE PRINT):	
INDIVIDUAL'S AUTHORIZING SIGNATURE:	DATE:

My signature above certifies that the above information is correct to the best of my knowledge. I also acknowledge acceptance of the rates and the corresponding designs listed as well as the Group Service Agreement. Group coverage will become effective only upon Fallon Health's acceptance of this application and payment of the required premium or fees at rates Fallon Health determines. Once approved, the effective date of coverage will be the effective date mutually agreed upon between Fallon Health and the employer, or the date the required number of employees who are to contribute to the cost of the coverage have enrolled, whichever is later.

Mail completed request form to:
Fallon Health, Attention: EDI Coordinator,
10 Chestnut St., Worcester, MA 01608-2810

Or email request form to:
edi.coordinator@fallonhealth.org

Or fax request form to:
1-508-368-9996

Fallon Health & Life Assurance Company, Inc. is a wholly owned subsidiary of Fallon Community Health Plan.

Notice of nondiscrimination

Fallon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Fallon does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Fallon Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Customer Service at the phone number on the back of your member ID card, or by email at cs@fallonhealth.org.

If you believe that Fallon Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Compliance Director
Fallon Health
10 Chestnut St.
Worcester, MA 01608

Phone: 1-508-368-9988 (TRS 711)
Email: compliance@fallonhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Director is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, D.C., 20201

Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you, or someone you're helping, has questions about Fallon Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-868-5200.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Fallon Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-868-5200.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Fallon Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-868-5200.

如果您，或是您正在協助的對象，有關於[插入項目的名稱 Fallon Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-868-5200.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Fallon Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-868-5200.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Fallon Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-868-5200.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Fallon Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-868-5200.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Fallon Health، فلديك الحق في الحصول على المساعدة والمعلومات

الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 1-800-868-5200.

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ំពី Fallon Health បេ, អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នា បៅកនុងភាសា ររស់អ្នក

បោយមិនអ្ស់ប្ាក់ ។ បែើមបីនិយាយជាមួយអ្នករកដប្រ សូម 1-800-868-5200 ។

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Fallon Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-868-5200.

Se tu o qualcuno che stai aiutando avete domande su Fallon Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-868-5200.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Fallon Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-868-5200로 전화하십시오.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Fallon Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-868-5200.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Fallon Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-868-5200.

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Fallon Health [के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी ्ुभाषषए से बात करने के लिए ,1-800-868-5200 पर कॉ् करें।

જો તમે અથવા તમે કોઇને મદદ કરી રહ્ાંાં તેમ ાંથી કોઇને Fallon Health વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. ૬ ભ વષર્ો િ ત કરિ મ ટે,આ 1-800-868-5200 પર કોલ કરો.

้าท่าน, ห ูือคนห ่ท่านกำลังช่อยเห ูือ, ม คำถามกังวลกับ Fallon Health, ท่านม
สิดห ่จะได้รับการช่อยเห ูือและข้มูนข่าวสารห ่เป็นภาษาของท่านโม่ม ค่าใช้จ่าย. การโอ้วมกับบายภาษา, โท้โทหา 1-800-868-5200.