Small Business Service Bureau, Inc.®

Health New England

SBSB Group Health Insurance Program for Sole-Proprietors and Small Employers in Massachusetts

Welcome! Enrollment in the health insurance plan of your choice is simple – ***only 3 easy steps***. Our Benefit Specialists are available to assist you and all information is confidential.

Step 1: **Obtain a premium quote** by contacting an SBSB Benefit Specialist at 1-800-472-7199, or by visiting us at www.SBSBHealth.com and click on Small Business Shopping for my Employees.

Step 2: **Apply for health insurance** by submitting the following to SBSB.

___ Completed Employer Group Application

___ Completed SBSB Group Health Census Form

___ Health Insurance Premium Quote

___ Have each employee participating in your group plan complete, sign, and date an Enrollment/Change Form. *(**Please note:** all dependent information including dates of birth must be accurate.)*

___ Waiver of Coverage Form for each employee opting out of your group insurance plan

___ Include Proof of Business Documentation **(choose at least 1)**

- Schedule C
- WR1
- Payroll Documents

___ Complete the SBSB Membership Application

Step 3: **Submit** the first month premium and SBSB Annual Membership Dues ($85 for 1-4 employees; $125 for 5-9 employees) payable to SBSB.

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872

or scan and email to:
enroll@sbsb.com

All groups subject to health plan eligibility and underwriting requirements.
All enrollment documents, including the employee's enrollment form, must be completed, signed, dated, and submitted to the Small Business Service Bureau, Inc. 10 days prior to the desired effective date.

Join SBSB!
A Big PLUS for Small Business Success!

Member Information

Business Name _____

Name of Owner/Operator ☐ Mr. ☐ Mrs. ☐ Ms.

_____

FIRST NAME MIDDLE INITIAL LAST NAME

_____

TITLE DATE OF BIRTH

Business Address

_____

STREET (NO P.O. BOXES)

_____

CITY STATE ZIP

Mailing Address (if different from street address above)

_____

STREET / P.O. BOX

_____

CITY STATE ZIP

Is your business address the same as your home address?

☐ Yes ☐ No Do you: ☐ Rent ☐ Own ☐ Lease?

Business Telephone (_____) _____

Home Telephone (_____) _____

Fax No. (_____) _____

E-mail _____

Number of Full-Time Employees _____

Description of Business: _____

_____

EXAMPLES: ACCOUNTING, LAW, RETAIL CLOTHING SALES, COMPUTER CONSULTING, ETC.)

Business Structure (check one)

☐ Corporation ☐ Sole Proprietorship
☐ Partnership ☐ Subchapter S

Does your company have a probationary period for new employees? ☐ No ☐ Yes If yes, what is it? _____

☐ **Yes, I want to save money on group insurance and other benefits for my small business!**

Complete this section only if applying for health insurance through SBSB.

Health Insurance Effective Date Desired ___/___/___

If you are applying for health insurance, do not cancel any insurance until you are certain your new coverage is in effect.

I hereby certify and attest the information provided herein is true and complete to the best of my knowledge, and that I have the legal authority to execute this document on behalf of the company named herein. I certify that 100% of eligible people who are not covered by a spouse, parent or Medicare are enrolled in the SBSB Health Insurance Program. Furthermore, I certify that all current and future employees to be enrolled actively work full-time, as defined by state and federal laws, for financial compensation. I understand all health coverage becomes effective upon the approval of the provider or carrier. I further state I am aware the health provider retains the right to terminate coverage at any time if the statements made herein are not true and complete.

For information or assistance with this application, call an SBSB Membership Representative Toll Free at

1-800-472-7199.

_____

AUTHORIZED SIGNATURE **TITLE**

___/___/___

PRINT NAME **DATE**

Please use the SBSB return-addressed envelope provided to submit your application(s).

Small Business Service Bureau, Inc.

A National Membership Organization for Small Business
38 Austin Street • P.O. Box 15014 • Worcester, MA 01615-0014

FOR SBSB USE ONLY

DATE _____ 090 _____ 260 _____ 400 _____

250 _____ 210 _____ 490 _____ 410 _____

240 _____ INITIAL BILL _____ EFF. DATE _____

REASON _____

Small Business Service Bureau, Inc.

Health New England

EMPLOYER GROUP APPLICATION (PAGE 1)

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872

or scan and email to:
enroll@sbsb.com

Please include:

❑ Employer Group Application ❑ Enrollment Forms ❑ Confirmation of Sold Rates

❑ Evidence of employment, which may include payroll records or WR-1. Please indicate employees who are part time and/or not eligible for coverage; employees who are waiving coverage; and employees who have terminated employment.

EMPLOYER ACCOUNT INFORMATION

COMPANY NAME			NATURE OF BUSINESS	SIC CODE	
				TAX ID#	
			BILLING CONTACT		
STREET ADDRESS			BILLING ADDRESS (IF DIFFERENT)		
PO BOX			CITY	STATE	ZIP
CITY	STATE	ZIP	PHONE	FAX	
GROUP CONTACT / TITLE			EMAIL ADDRESS		
			BENEFITS ADMINISTRATOR (IF ANY)		
PHONE	FAX		BENEFITS ADDRESS (IF DIFFERENT)		
EMAIL ADDRESS			CITY	STATE	ZIP
COMPANY WEBSITE			PHONE	FAX	
			EMAIL ADDRESS		

# OF ELIGIBLE EMPLOYEES	# OF EMPLOYEES ENROLLING	RETIREES (AGE 65+ W/MED A&B)	# OF COBRA ENROLLING	DOMESTIC PARTNER COVERAGE ❑ YES ❑ NO If yes, please include domestic partner rider

TOTAL NUMBER OF EMPLOYEES (INCLUDE ALL FULL- AND PART-TIME EXEMPT EMPLOYEES SUBJECT TO FICA TAXES)* _____

* THIS INFORMATION IS NECESSARY IN ORDER TO CLASSIFY YOUR COMPANY CORRECTLY FOR FEDERAL MEDICARE SECONDARY PAYER (MSP) REQUIREMENTS.

IMPORTANT: The employer must notify Health New England within five (5) business days of when the total number of employees either increases to 20 or more or drops below 20 during the contract year. HNE will validate the total number of employees at the group's renewal date.

GROUPS FOUND TO HAVE MISREPRESENTED ANY OF THE ABOVE INFORMATION MAY BE SUBJECT TO IMMEDIATE CANCELLATION, WITH NO CONVERSION PRIVILEGES.

EMPLOYER CONTRIBUTION

HNE HAS A MINIMUM REQUIREMENT OF 50% OF SINGLE RATE

COMPANY CONTRIBUTION (PERCENT OF PREMIUM OR DOLLAR AMOUNT CONTRIBUTED TOWARD MONTHLY RATE) _____

IF APPLICABLE: EMPLOYER CONTRIBUTION PERCENTAGE CONTRIBUTED TO RETIREE COVERAGE _____

HNE PLAN INFORMATION (PAGE 2)

REQUESTED EFFECTIVE DATE	ANNIVERSARY DATE	NEW HIRE WAITING PERIOD

PLAN NAME:	HSA	HRA	RATE TIER TYPE	Rx COPAYS:	CHIRO COPAYS:
PLAN NAME: ________ ________	❑	❑	RATE TIER TYPE Tier 2 ❑ Tier 3 ❑ Tier 4 ❑ Other ❑ ________	Rx COPAYS: ________ ________	CHIRO COPAYS: ________ ________
PLAN NAME: ________ ________	❑	❑	RATE TIER TYPE Tier 2 ❑ Tier 3 ❑ Tier 4 ❑ Other ❑ ________	Rx COPAYS: ________ ________	CHIRO COPAYS: ________ ________
PLAN NAME: ________ ________	❑	❑	RATE TIER TYPE Tier 2 ❑ Tier 3 ❑ Tier 4 ❑ Other ❑ ________	Rx COPAYS: ________ ________	CHIRO COPAYS: ________ ________

* Please verify with your sales representative which plans offer calendar year or policy year deductibles.

COBRA BILLING OPTIONS

This is a billing method only and Employer Groups are still required to follow all other COBRA responsibilities.

❑ **Individual Bill COBRA (Preferred billing method for groups with less than 51 eligible employees):**
Premium invoice will be sent directly to COBRA participant. HNE adds a 2% administration fee to premium due as allowed by COBRA regulations.

❑ **Group Bill COBRA:**
Premium invoice will be sent to the Employer Group for COBRA Participants. Employer Group is responsible for collecting COBRA premium and submitting payment to HNE.

EMPLOYER GROUP CERTIFICATION

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 by Health New England (HNE). I understand and agree that any coverage issued shall be subject to the terms of the HNE Employer Agreement. I acknowledge that I have received a copy of the HNE Employer Agreement. I also acknowledge that coverage is not effective until approved by HNE and that the requested effective date may be deferred if the information submitted is incomplete. As required under MGL c. 176G § 6A and as further set forth in the HNE Employer Agreement, I also specifically agree that the group is contracting with HNE to offer benefit plan(s) to all full-time employees who live in Massachusetts, and that the health insurance premium contributions for the benefit plan(s) made by the group are not smaller for full-time employees who earn lower wages, computed hourly or annually, than for other full-time employees who receive an equal or greater total hourly or annual salary.

(X)

SIGNATURE OF COMPANY OFFICIAL	TITLE	DATE

BROKER OF RECORD ASSIGNMENT

The group designates the broker named below as Broker of Record to obtain and receive information from HNE on the group's behalf and to receive commissions which may become payable upon acceptance of this application by HNE.

BROKER NAME	COMPANY		
ADDRESS	CITY	STATE	ZIP

Small Business Service Bureau, Inc.®
A National Membership Organization for Small Business
38 Austin Street, P.O. Box 15014, Worcester, MA 01615-0014

Company Name: _____

Address: _____

_____

Requested Health Plan: _____

Broker Name: _____
(if applicable)

Broker Number: _____

Group Census Form

Total number of employees (ACA Definition*):
Number of full-time and full-time equivalent employees (FTE's), including any part-time and seasonal employees who are employed at the time of the policy effective date working 30 or more hours per week. _____

Do you regularly employ at least one individual that is not an owner and/or family member of an owner? _____Yes _____No

Include all benefit eligible employees on payroll and any COBRA participants. Please attach additional listing if needed.

Employee Name	Covered by other group insurance? (yes/no)	Covered by spouse? ** (yes/no)	Date of Birth	Date of Hire	Full/Part Time (Hrs. worked)
1.					
2.					
3.					
4.					

Signed: _____ Date: _____
Authorized Company Representative

Name: _____
Please Print

Return All Copies to SBSB

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872
or scan and email to:
enroll@sbsb.com

*To determine the FTE count we recommend using https://www.healthcare.gov/shop-calculators-fte/.
**If waiving right to group health care coverage at this time, please attach a completed waiver of coverage form.

If you have questions or need assistance, please contact SBSB at 1-800-472-7199

Health New England

One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

ENROLLMENT/ADD/TERMINATION FORM

PLEASE PRINT AND/OR TYPE INFORMATION. PRINT TO SIGN.

Clear Form

EMPLOYEE NAME (FIRST, LAST)	COMPANY NAME	PLAN
PRIMARY CARE PROVIDER (PCP) (REQUIRED FOR HMO PLANS)	(PCP) PROVIDER ID# (REQUIRED FOR HMO PLANS)	IS THIS YOUR DOCTOR NOW? ☐ YES ☐ NO
SS# (REQUIRED) - -	DOB MONTH DAY YEAR - -	GENDER ☐ MALE ☐ FEMALE
ADDRESS STREET	APT NO.	P.O. BOX
CITY	STATE	ZIP
TELEPHONE (HOME) ( )	TELEPHONE (WORK) ( )	EMAIL
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER	PRIMARY LANGUAGE SPOKEN	
ETHNICITY (use codes from back of form) 1ST	2ND	OTHER / RACE (Use codes from back of form)

WILL ANYONE COVERED ON THIS POLICY KEEP OTHER HEALTH INSURANCE? ☐ YES ☐ NO

NAME OF INSURANCE CO. _____ POLICY # _____

NAMES OF COVERED INDIVIDUALS _____

IS EMPLOYEE RETIRED? ☐ YES RETIREMENT DATE _____ ☐ NO

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE?* ☐ YES ☐ NO

IF YES, ☐ PART A ☐ PART B INCLUDE COPY OF MEDICARE CARD

MEDICARE CLAIM # _____

**If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

FOR GROUP MEDICARE SUPPLEMENT MEMBERS: WILL THIS POLICY REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE CURRENTLY IN FORCE? ☐ YES ☐ NO

DEPENDENT NAME(S) FIRST LAST (IF NOT SAME AS EMPLOYEE)	ETHNICITY (SEE REVERSE)	RACE (SEE REVERSE)	LANGUAGE (SEE REVERSE)	DATE OF BIRTH MO DAY YR	GENDER	SOCIAL SECURITY # (REQUIRED)	PCP NAME (REQUIRED FOR HMO PLANS) FIRST LAST	PROVIDER ID#	IS THIS YOUR DOCTOR NOW?
☐ SPOUSE ☐ OTHER				- -	Gender	- -			Y/N
				- -	Gender	- -			Y/N
				- -	Gender	- -			Y/N
				- -	Gender	- -			Y/N

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, HEALTH NEW ENGLAND AND ANY HEALTH CARE PROVIDER MAY RECEIVE, USE AND DISCLOSE MY MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND ANY AND ALL OTHER USES ALLOWED BY LAW. I HAVE READ AND UNDERSTAND THE TERMS OF ENROLLMENT ON THE BACK OF THIS FORM. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

(X) _____

EMPLOYEE SIGNATURE DATE

BELOW SECTION TO BE COMPLETED BY EMPLOYER

EFFECTIVE DATE _____ (new enroll choose qualifying event below)

☐ **NEW ENROLLMENT** ☐ **ADD DEPENDENT** ☐ **CHANGE MEMBER INFO**

CHOOSE REASON:

☐ **NEW HIRE** (DATE OF HIRE REQUIRED) ☐ **LOSS OF INSURANCE** ☐ **ANNUAL OE** **OTHER** _____ (SPECIFY)

☐ **TRANSFER TO COBRA**

CHOOSE ONE: ☐ **HNE COBRA** ☐ **HNE COBRA WITH HEALTH EQUITY HRA**

☐ **TERM POLICY** ☐ **TERM DEPENDENT** **END DATE** _____

CHOOSE REASON:

☐ **LEFT EMPLOYMENT** ☐ **MOVED** ☐ **VOLUNTARY CANCEL**

☐ **COBRA TERM** ☐ **NO LONGER ELIGIBLE** ☐ **DECEASED**

TYPE OF PLAN: ☐ **HMO** ☐ **PPO** ☐ **GROUP MEDICARE SUPPLEMENT**

TYPE OF COVERAGE: ☐ **INDIVIDUAL** ☐ **FAMILY** ☐ **EE+1** ☐ **OTHER**

DATE OF HIRE: _____ **HNE GROUP #:** ☐☐☐☐☐☐ – ☐☐☐☐

(X) **EMPLOYER SIGNATURE** _____ **DATE** _____

IMPORTANT: PLEASE READ THESE TERMS OF ENROLLMENT

As an employee, I understand that:

1. By submitting this form or accepting coverage under the plan, I agree, on behalf of myself and all enrolled dependents, to abide by the terms of the Health New England (HNE) Agreement, which includes this form as well as the applicable Explanation of Coverage or Summary Plan Description.

2. Membership will become effective upon acceptance by the Plan and that benefits under the Plan will be explained in a separate document (Explanation of Coverage or Summary Plan Description).

3. I may only enroll dependents subject to the guidelines outlined in my HNE Agreement.

4. Whenever I seek treatment or services, I must identify myself as an HNE member by presenting my HNE Identification Card.

5. I must select a Primary Care Physician for myself and my dependents (does not apply to PPO).

6. If appropriate, I authorize my employer to deduct from my wages the rate required for the coverage selected.

As an employer, I understand that:

1. **By submitting this form, I certify that the information provided on this form is accurate.**

RACE & ETHNICITY

Why are these questions being asked?

The Commonwealth of Massachusetts has established statewide goals for improving health care quality and reducing racial and ethnic disparities in health care. HNE wants to do our part to remove any barriers to fair and unbiased treatment for all of our members. By collecting information about your race and ethnic background, we may be able to identify possible issues that affect the care or treatment you receive. HNE will then be able to work with our provider community to address any issues. We appreciate your assistance in this effort.

This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment. HNE keeps this information confidential according to our policies and state and federal law.

RACE Please choose from the following:
Fill in the code where indicated on the front of this form.

Code	Description
R1	American Indian/Alaska Native
R2	Asian
R3	Black/African American
R4	Native Hawaiian or other Pacific Islander
R5	White
R9	Other Race
UNKNOWN	Unknown/not specified

ETHNIC GROUP **Please choose from the following: you may choose more than one. Fill in the code where indicated on the front of this form.**

Code	Description
2182-4	Cuban
2184-0	Dominican
2148-5	Mexican, Mexican American, Chicano
2180-8	Puerto Rican
2161-8	Salvadoran
2155-0	Central American (not otherwise specified)
2165-9	South American (not otherwise specified)
2060-2	African
2058-6	African American
AMERCN	American
2028-9	Asian
2029-7	Asian Indian
BRAZIL	Brazilian
2033-9	Cambodian
CVERDN	Cape Verdean
CARIBI	Caribbean Island
2034-7	Chinese
2169-1	Columbian
2108-9	European
2036-2	Filipino
2157-6	Guatemalan
2071-9	Haitian
2158-4	Honduran
2039-6	Japanese
2040-4	Korean
2041-2	Laotian
2118-8	Middle Eastern
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOWN	Unknown/not specified

Small Business Service Bureau, Inc.®

Waiver/Verification of Alternative Coverage

Eligible Employees who refuse the SBSB Group Insurance Plan offered through their employer must verify they have alternative coverage.

I,_____ , certify that I am an employee of and that I am eligible for group health care coverage through_____ , my employer. I also certify that I am waiving my right to group health care coverage through my employer at this time because I have chosen health care coverage through ***(Check box that applies)***:

❑ COBRA ❑ Parent/Spouse ❑ Union ❑ Medicare ❑ Alternate group health program

Parent's / Spouse's Name: _____

Current Health Plan: _____

Health Plan Identification Number: _____

Group / Policy Number:_____

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that any person choosing to enroll later must meet the health plan's requirements for eligibility and for late enrollees.

Employee Name *(please print)*

Signature Date

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that the health plan has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Signature of Authorized Company Representative Date

If you have any questions, please contact SBSB at 1-800-472-7199 *(existing membership)*

Return with the completed census and required documents to:
Small Business Service Bureau, Inc.
38 Austin Street • PO Box 15014 • Worcester, MA 01615-0014

Health New England
Where you matter.

altus dental™
Altus Dental Insurance Company, Inc.

Pediatric Dental Benefits

Protect Your Child's Smile

An unhealthy mouth impacts a child's ability to learn, develop self-esteem and speak properly. Furthermore, issues with oral health such as tooth decay can be associated with physical conditions like obesity, diabetes and heart disease. That's why your plan with Altus Dental covers 100%* of sealants and fluoride treatments for your children under age 19. Sealants and fluoride treatments can help prevent tooth decay and can help your child's smile stay happy and healthy.

*percentage reflects in-network coverage

Diagnostic & Preventive

Exams, X-Rays, Cleanings, Fluoride Treatment, Sealants

Minor Restorative

Silver and White Fillings, Recementing crowns

Major Restorative

Crowns, build ups, posts and cores

Orthodontics & Oral Surgery

Medically Necessary Braces, Extractions

For more info go to
altusdental.com/HNE