

COMPANY INFORMATION:			
COMPANY NAME		SIC CODE	TAX ID #
COMPANY ADDRESS		TOTAL # OF EMPLOYEES	
CITY		STATE	ZIP CODE
PHONE	FAX	WEB SITE	
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)			
CITY		STATE	ZIP CODE
CURRENT CARRIER MOVING FROM		RATES	
DO YOU HAVE HEALTH REIMBURSEMENT ARRANGEMENT (HRA) OR ALTERNATIVE FUNDING?* <input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU CURRENTLY OFFER DOMESTIC PARTNER BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMPLOYER CONTRIBUTION % _____ OR \$ _____			
DO YOU CURRENTLY OFFER A SECTION 125 PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHO IS THE SECTION 125 ADMINISTRATOR?	

CONTACT INFORMATION:		
EXECUTIVE/OWNER	PHONE	E-MAIL
BILLING CONTACT	PHONE	E-MAIL
BENEFITS ADMINISTRATOR	PHONE	E-MAIL

PLAN INFORMATION:		
EFFECTIVE DATE	ANNIVERSARY DATE (PLEASE CHECK ONE) <input type="checkbox"/> 1 ST OF THE MONTH <input type="checkbox"/> 15 TH OF THE MONTH	
PROBATIONARY PERIOD	TOTAL # OF BENEFIT ELIGIBLE EMPLOYEES	TOTAL # OF COBRA
NETWORK (FCHP DIRECT CARE, FCHP SELECT CARE, FALLON PREFERRED CARE)	PLAN NAME	CONFIRM PROPOSED RATES**

BROKER INFORMATION (IF APPLICABLE):	
PRIMARY BROKER NAME	
BROKER AGENCY	
COMMISSIONS MADE PAYABLE TO:	
SECONDARY BROKER NAME	COMMISSION SPLIT (IF APPLICABLE) <input type="checkbox"/> 50/50 <input type="checkbox"/> 70/30 <input type="checkbox"/> 60/40 <input type="checkbox"/> 80/20
SECONDARY BROKER AGENCY	

Fallon Community Health Plan requires Brokers to fully disclose to their current and prospective clients all commissions and fees payable to the Broker by FCHP in connection with the sale of proposed group insurance coverage(s) and services.

I certify that the above information is correct to the best of my knowledge. I also acknowledge acceptance of the rates and corresponding designs listed as well as the Group Service Agreement (GSA).

Signature of authorized company representative

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



*FCHP may contact you regarding additional information and/or documentation.
**This acknowledges your acceptance of the group's proposed premium rates. At FCHP's discretion these rates are subject to review and underwriting approval.