

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 CURRENTLY HAVE A HEALTH REIMBURSEMENT ARRANGEMENT (HRA), FLEXIBLE SPENDING ACCOUNT (FSA), OR HEALTH SAVINGS ACCOUNT (HSA)? <input type="checkbox"/> YES <input type="checkbox"/> NO CHECK ALL THAT APPLY: <input type="checkbox"/> HRA <input type="checkbox"/> FSA <input type="checkbox"/> HSA <input type="checkbox"/> NONE IF YES, HOW MUCH DO YOU, AS THE EMPLOYER, CONTRIBUTE ANNUALLY? \$ _____ OR % _____ WHO IS THE THIRD PARTY ADMINISTRATOR? <input type="checkbox"/> ULTRABENEFITS <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____			DO YOU CURRENTLY OFFER DOMESTIC PARTNER BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO
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	TITLE	PHONE	E-MAIL
BILLING CONTACT	TITLE	PHONE	E-MAIL
BENEFITS ADMINISTRATOR	TITLE	PHONE	E-MAIL

PLAN INFORMATION: PLAN YEAR CALENDAR YEAR

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, FCHP TIERED CHOICE, FCHP STEWARD COMMUNITY 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 _____



* 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.

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

FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice provide access to networks that are smaller than the FCHP Select Care network. In these plans, members have access to network benefits only from the providers in their respective network. Please consult the respective provider directory – paper copies can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fchp.org to determine which providers are included in FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice.

FCHP Tiered Choice members have access to network benefits only from the providers in FCHP Tiered Choice, and may pay different levels of copayments, coinsurance and/or deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on January 1.