

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* <small>(i.e. 834/FTP Access)</small>	PICK UP ELECTRONIC REPORTS* <small>(i.e. 999/FTP Access)</small>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*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.



Billing agency/broker authorization form

To grant secure access to a third party billing agency or broker for Fallon Health's Employer Tools on fallonhealth.org, please fill out the form below. Upon receipt and review by Fallon Health, your assigned username and password will be forwarded to each authorized individual. If you do not hear back from us **within 15 business days**, please call 1-800-333-2535, option 6, to confirm receipt.

Billing agency/broker information

Billing agency/broker name:		Customer number:	
Legal name of employer organization (please print):		Employer Identification Number (EIN) of employer being represented:	
Street address (line 1):			
Street address (line 2):			
City:		State:	ZIP:
Telephone number:		Fax number:	
Contact name/title:		Contact email address:	

Agreement terms

The undersigned employer authorizes the above-named billing agency/broker access to Employer Tools on fallonhealth.org to submit data to Fallon Health on the employer's behalf. As such, the employer accepts full liability for all actions of the above-named billing agency/broker and is responsible for any violations of laws and regulations.

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 immediately by calling 1-800-333-2535, option 6, if I believe a password has been compromised. I will notify Fallon Health to disable access when an employee's responsibilities no longer require using Employer Tools or when an employee terminates.

I understand that as the employer/broker, 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 I have designated access. The undersigned agrees to indemnify and hold harmless Fallon Health for any breach of this confidentiality agreement, and shall be liable to Fallon Health 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 Health'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 Health to receive and process eligibility electronically in accordance with applicable regulations. I assure that all information submitted is accurate and any claims submitted in falsification are prosecutable under state and/or federal laws.

Signatures

Individual signing for employer organization/title (please print):	Individual's authorizing signature:	Date:
Billing agency/broker name/title (please print):	Billing agency/broker signature:	Date:

Mail completed request form to:

Fallon Health | Attention: EDI Coordinator
10 Chestnut St. | Worcester, MA 01608-2810

Or email it to: edi.coordinator@fallonhealth.org

Or use Fax number: 1-508-368-9996



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.