

# FCHP Rate Summary and Acceptance Form



fallon health & life assurance company, inc.

COMPANY NAME	EFFECTIVE DATE OF COVERAGE
PLEASE INDICATE NETWORK(S) AND PLAN NAME(S):	
1. _____	RATES _____
2. _____	RATES _____
3. _____	RATES _____
4. _____	RATES _____

**YOUR SIGNATURE BELOW ACKNOWLEDGES ACCEPTANCE OF THE RATES AND CORRESPONDING DESIGNS LISTED AS WELL AS THE GROUP SERVICE AGREEMENT.**

CONTACT	TITLE
EMAIL ADDRESS	
BUSINESS ADDRESS	
PROBATIONARY PERIOD/WAITING PERIOD FOR NEW HIRES	TAX IDENTIFICATION NUMBER

BILLING CONTACT	TELEPHONE
BILLING ADDRESS	PREVIOUS CARRIER

COMMISSIONS MADE PAYABLE TO:  _____ PRIMARY BROKER NAME  _____ OTHER BROKER NAME (IF APPLICABLE)	COMMISSION SPLIT
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Signature \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

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