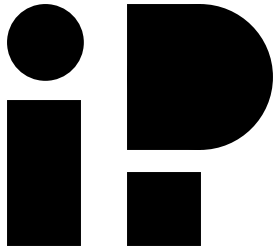


EMPLOYER APPLICATION



Insurance Partnership
From the Commonwealth of Massachusetts

Please Mail to:
Insurance Partnership
2 Hampshire Street, #100
Foxboro, MA 02035

Employers Please Include:

Copy of Quarterly Wage & Tax Statement (WR-1)
Copy of **Previous** Months Health Insurance Bill
Broker/Agent Name (If Applicable): _____

REASON FOR APPLICATION

PLEASE CHECK ONE:
NEW APPLICATION: REVISED INFORMATION: REQUESTED EFFECTIVE DATE FOR APPLICATION/REVISIONS:
Date: _____ / _____ (MM/YY)

COMPANY INFORMATION

LEGAL NAME OF FIRM		CORPORATION <input type="checkbox"/> PARTNERSHIP PROPRIETORSHIP	FEDERAL TAX ID NUMBER (FEIN):
CONTACT NAME & TITLE	COMPANY NAME TO APPEAR ON STATEMENT		TYPE OF BUSINESS SIC CODE:
ADDRESS	CITY	STATE	ZIP CODE+4
NATURE OF BUSINESS			BUSINESS START DATE (mm/yyyy)
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE+4
TELEPHONE	FACSIMILE		E-MAIL ADDRESS
PLEASE LIST ANY ADDITIONAL COMPANY NAMES (DBA'S)		NO. OF FULL-TIME EMPLOYEES:	EST. NO. ELIGIBLE FOR THE INSURANCE PARTNERSHIP:

INSURANCE INFORMATION

HEALTH INSURANCE COMPANY:	HEALTH PLAN INFORMATION: DEDUCTIBLE (IF ANY): \$ _____ DOCTOR VISIT COPAY: \$ _____	GROUP INSURANCE NUMBER:	POLICY RENEWAL DATE: (yyyy-mm-dd)
PLAN NAME:			

COMPANY PREMIUM AND CONTRIBUTION INFORMATION*

PLAN COVERAGE:	CURRENT MONTHLY PREMIUM:	EMPLOYER CONTRIBUTION %:	EMPLOYER CONTRIBUTION \$:	IF ANY ADDITIONAL EMPLOYEE CLASSES PLEASE LIST:
EMPLOYEE ONLY				CLASS CONTRIBUTION%
EMPLOYEE AND CHILD(REN)				CLASS CONTRIBUTION%
EMPLOYEE AND SPOUSE				CLASS CONTRIBUTION%
EMPLOYEE AND FAMILY				CLASS CONTRIBUTION%

Date company began contributing at least 50%: _____ / _____ (MM/YY)

***PLEASE NOTE THAT EMPLOYEES ARE NOT ELIGIBLE IF THE EMPLOYER CONTRIBUTION IS LESS THAN 50%**

