Corporate Office
141 Longwater Drive, Suite 112
Norwell, MA 02061
(781) 228-2222

Membership Application

Please complete each section of this application. Failure to do so could delay enrollment.

Employer information

Employer name_____Date business established (Mo./Yr.) ____/____

Employer address _____

City _____State _____Zip _____

Owner/principal contact name (first and last) _____Title_____

Business Phone _____Cell phone _____Fax _____

Email _____Website _____

Billing address _____

City_____State _____Zip _____

Type of business ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ LLC ❑ Other: _____

Nature of business: _____

Employer tax ID# _____SIC code_____

Do you regularly employ at least one individual that is not an owner and/or the spouse of an owner? ❑Yes ❑ No

Number of full-time employees (30 hours or more per week; including owner) _____

Number of part-time employees (less than 30 hours per week) _____

Quote # (from Group Proposal) _____

Certification and Disclosures

1. The company named above is a bona fide business and not in operation for the sole purpose of obtaining health insurance.
2. All enrollees are actively working for financial compensation and are covered by Worker's Compensation as required by law.
3. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
4. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
5. Payments not received by the 10th of the month are subject to a late fee, currently $50.
6. Payments not received by the 20th of the month are subject to a pending termination fee, currently $75.
7. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier. Reinstatements are subject to a reinstatement fee, currently $75.
8. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $50.
9. Member firms must maintain good standing in their respective Business Association or Chamber of Commerce to participate in the group insurance programs offered through HSA.
10. HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.
11. HSA Insurance charges a monthly service fee per account.

I certify that the information on this form is true and complete, that I understand and agree to the above administrative requirements, and that I have the legal authority to sign on the company's behalf.

Signature _____Title _____Date _____

Broker name (if applicable) _____

Address_____
City _____State _____ZIP _____

For office use only