Membership Application

RETAILERS ASSOCIATION of MASSACHUSETTS

MASSACHUSETTS PACKAGE STORES ASSOCIATION INC

NORTHEASTERN RETAIL LUMBER ASSOCIATION

How to complete your application

Thank you for choosing the Retailers Association of Massachusetts Health Insurance Cooperative (the Cooperative) for your health insurance coverage. Enclosed you will find the information and forms necessary to complete your application.

Please read the instructions carefully and complete the five steps. The requested information should be returned immediately to your RAMHIC certified broker along with your deposit check. It is important that ALL information requested is completed accurately. Misinformation may delay the issuance of your policy.

Step 1 Sign and return a copy of the **Membership Agreement** (pages 2-6).

Step 2 If you are a current RAM, MassPack, or NRLA member, complete, sign and return the **Qualified Association Member Verification** form (page 7), and proceed to Step 4.

Step 3 If you are not a current member of either RAM or MassPack, complete the applicable association application along with a check made payable to the designated association *(pages 8 or 9).

Please note that you must join or be a member of one of the associations to obtain coverage from the cooperative.

Step 4 Forward forms and dues checks to either your RAMHIC certified broker or to RAM directly.

Step 5 Contact BCBSMA at 800-262-2583 or FCHP at 866-906-0099 to request a rate quote.

Thank you for taking the time to fill out this application accurately.
A copy of all documents submitted should be retained for your files.

* If you are entering into the **Massachusetts Package Stores Association**, please complete program document on page 8. If you are entering into the **Retailers Association of Massachusetts**, please complete the program document on page 9. Thank you.

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Membership Agreement

of the Retailers Association of Massachusetts Health Insurance Cooperative

THIS AGREEMENT is made as this ______ day of __________ , 20___ by and between the Retailers Association of Massachusetts or its assigns (the Cooperative) and the undersigned Qualified Association Member located in the Commonwealth of Massachusetts, (the "Member").

WHEREAS, the Cooperative has applied to the Massachusetts Commissioner of Insurance (the "Commissioner") for a certificate of approval to operate as a group purchasing cooperative under St. 2010. c. 288 and M.G.L. c. 176J, §§ 12 and 13 (the "Statutes"); and

WHEREAS, the Member desires to become a member of the Cooperative to obtain health insurance coverage.

NOW, THEREFORE, in consideration of the mutual covenants and premises herein contained, the Cooperative and the Member agree as follows:

1. **Definitions.** For the purpose of this Agreement, terms herein shall carry the definition provided by 211 CMR 151.03.

2. **Representation, Member Eligibility and Warranty by the Member.** The Member represents and warrants that

(a) it is engaged in the business of providing retail services, and is a Member in good standing of a Qualified Association which has contracted with the Cooperative to obtain health insurance coverage for its members,

(b) it acknowledges that its ability to obtain health insurance coverage through the Cooperative is conditioned upon continued membership in said Qualified Association,

(c) it falls within the scope of the definition of an Eligible Small Business, as defined under 211 CMR 151.03. In particular, the applicant agrees that it does not employ more than 50 *eligible* employees in Massachusetts,

(d) if the Member is an Eligible Small Business, it shall offer the Cooperative obtained health insurance coverage exclusively to its Eligible Employees and Eligible Dependents,

(e) it has not chosen to cease being offered a Health Benefit Plan through a Group Purchasing Cooperative in the past three years.

3. **Conditions Precedent to Effectiveness of Agreement.** This Agreement shall not be effective unless and until (a) the Cooperative receives from the Commissioner, a certificate of approval as a group purchasing cooperative under the "Statute" or regulations promulgated pursuant thereto, (b) the Cooperative accepts the Member's application to become a member of the Cooperative.

4. **Bylaws, Rules, Regulations, Policies and Procedures.** The Member shall abide by the bylaws and any other rules, regulations, policies and procedures adopted by the Cooperative from time to time.

5. **Coverage.**

(a.) Upon the later of the date the Member's application for coverage has been approved, or the date upon which all conditions precedent to the effectiveness of this Agreement, as set forth in Section 3 above, have been satisfied, the Cooperative agrees to negotiate with one or more Carriers to obtain health insurance coverage for its members and provide members with the wellness services described in Section 9 of this Agreement.

(b.) Any Health Benefit Plan obtained by the Cooperative shall offer at least two dates annually for enrollment. Applicants and their Eligible Employees shall be eligible for that enrollment date following approval of this application.

(c.) The Member agrees to pay the premiums, assessments, and entry fee, if any, as provided herein, for such services and coverage, and all costs of collection thereof, including attorneys' fees.

6. Premiums.

(a.) The Member agrees to pay to their issuing Carrier, which has contracted with the Cooperative to issue health insurance, premiums computed in accordance with a rating plan, as amended from time to time, on file with the Commissioner.

(b.) The Member agrees to pay its premium for the initial policy in accordance with the premium payment plan established by the Carrier, filed with the Commissioner and approved by the Cooperative. The Cooperative reserves the right to amend the premium Payment Plan as the same may be amended.

(c.) The Member understands that there may be interim rate adjustments approved by the Commissioner and agrees to pay additional premiums resulting therefrom. The Member also agrees to pay additional premiums to the Issuing Carrier in accordance with the bylaws or rules of the Cooperative based upon recommendations and regulations of the Cooperative or otherwise required by law.

(d.) The Member agrees to execute necessary authorization forms permitting the Cooperative or its assigns to obtain information and data required in determining the health risk of the Member and authorizing the Cooperative or its assigns to file with the appropriate authorities, loss, wellness and health data pertaining to the Member.

(e.) The Member acknowledges that a monthly administrative fee of $4.00 per month per member may be charged to all covered individuals for the administration of the Cooperative and the wellness program discussed in section 9 below. The fee shall take the form of a premium assessment applied to the account of subscribing employees. While the fee shall not increase during a given plan year, the member understands changes in the fee amount may be made upon written notice 30 days prior to renewal.

7. Entry Fee for New Members. New members agree to pay to the Cooperative a one-time initial membership fee in an amount reasonably necessary to cover the cost of administering the Cooperative's programs, as determined by the Cooperative at the beginning of each plan year. The entry fee shall not exceed $500;

8. Reasonable Special Assessments. The member acknowledges that in the event the Cooperative is not able to generate the resources necessary to pay its expected expenses, the Cooperative may impose a reasonable special assessment on Members to cover said expenses only. The member agrees to pay any reasonable special assessment deemed necessary by the Cooperative. Notification of a reasonable special assessment shall be given to the Member in writing 30 days prior thereto.

9. Wellness Programs.

(a.) The Cooperative, through its third party insurance Carriers, will provide wellness programs to the Member, designed to assist the Member in following a plan which may result in reduced losses and costs. The Member may elect to cooperate by participating in the wellness offering of their selected Carrier. Notwithstanding the Cooperative's and Carriers' responsibility for the wellness programs, the Cooperative and the Carriers are in no way ensuring the well-being or increased health of the members.

(b.) The Member is aware of the Cooperative's obligation to ensure that 33% of covered members are enrolled in the offered wellness programs and agrees to assist the Cooperative in reaching the required participation level.

(c.) The Member agrees to maintain an annual Wellness Program participation level of 50% of its eligible employees who are enrolled in a Health Benefits Plan offered through the Cooperative in order to remain eligible for membership and coverage through the Cooperative. Failure to maintain this required level of participation may result in non-renewal of membership in the Cooperative and non-renewal of coverage offered through the RAM Cooperative according to the following:

(i) Members whose participation level falls below 50% but not less than 33% in a given year, shall, upon notification, be given a probationary period of one year to increase their participation level to the required 50%. Failure to return the participation level to 50% during this period may result in non-renewal of coverage offered by the RAM Cooperative upon the following anniversary renewal date of the policy.

(ii.) Members whose participation level falls below 33% in a given year, shall be notified of their failure to comply with the terms of this membership agreement and that their coverage obtained through the RAM Cooperative shall be non-renewed upon the following anniversary renewal date of the policy.

(d.) Eligible participation shall consist of Covered Individuals successfully enrolling and completing the wellness program requirements set forth by their selected Carrier:

(i.) For individuals covered through BCBSMA, participation is met through completion of BCBSMA's "Healthy Actions" program. A Covered Individual must first complete the program's health assessment survey and then request his or her doctor to fill out a Clinician Health Review form. (1) If the Clinician Health Review form indicates that the Covered Individual is healthy, then participation is complete upon submission of the form to the wellness vendor. (2) If the Clinician Health Review form indicates that the Covered Individual needs to improve his or her health then the Covered Individual's doctor will set a list of health goals to be met before the end of the plan year. Participation is complete once the goals are achieved to the satisfaction of the Covered Individual's doctor and a subsequent Clinician Health Review form indicating such is completed and submitted to the wellness vendor.

(ii) For individuals covered through FH, participation is met through completion of FH's "My Healthy Health Plan" program. A Covered Individual must first complete the program's health assessment survey. Based on the results of the survey, the program generates a Wellness Score for each individual. The Wellness Scores are divided into three categories—Low Risk, Moderate Risk and High Risk. (1) Covered Individuals receiving a Wellness Score between 80 and 100 are considered Low Risk and no further action is necessary to satisfy the participation requirement. (2) Covered Individuals receiving a Wellness Score between 60 and 79 are considered Moderate Risk and must complete 8 weeks of wellness workshops to satisfy the participation requirement. (3) Covered Individuals receiving a Wellness Score of 59 and below are considered High Risk and must complete 8 weeks of wellness workshops in addition to 4 sessions of health coaching to satisfy the participation requirement.

(e.) For covered individuals without internet access, eligible participation may be realized by alternative means adopted by the Carrier's wellness provider.

(f.) Federal ADA standards require a reasonable alternative to be provided for access to a wellness program for people with

disabilities. For the individuals living with a disability access to the Wellness Program will be made available through the alternative options adopted by the Carrier's wellness provider.

(g.) If a covered individual who is living with a disability cannot use any of the alternative options, including a screen reader – then a waiver, exempting said individual from the participation requirements shall be issued.

10. Claims. All claims arising under a Health Benefit Plan obtained through the Cooperative shall be administered, investigated, negotiated, adjusted, settled, and paid, exclusively by the Carrier issuing the certificate of coverage. The Cooperative or its Administrator or designee shall not be responsible for the handling or payment of any claims arising under a Health Benefit Plan obtained thereby.

11. Termination of Membership and Non-renewal of Coverage.

(a) This Agreement and the Member's membership in the Cooperative and Coverage thereunder may be terminated by the Cooperative for failure to comply with the terms of this Agreement or the bylaws, rules, regulations, policies or procedures of the Cooperative including, but not limited to, the failure to pay premiums.

(b) The Member may withdraw its membership and coverage by giving the Cooperative prior written notice of its intention to withdraw at least sixty (60) days. Any early termination of health insurance coverage obtained through the Cooperative shall preclude the Member from obtaining health insurance coverage though the Cooperative for a period of three years.

(c) Termination of membership in a Qualified Association, which has contracted with the Cooperative to obtain coverage for its members, for any reason, including failure to pay required membership dues, shall preclude the Member from obtaining health insurance coverage through the Cooperative or an alternative group purchasing cooperative for a period of three years following expiration of their existing policy.

(d) Membership may be terminated if the Member or the Member's eligible employees and eligible dependents do not adhere to the written participation requirements adopted by the Cooperative regarding the Wellness Program described by Section 9 of this agreement. Termination for failure to participate shall be at the discretion of the Cooperative pursuant to established participation requirements.

(e) Coverage obtained by the Association Member for its eligible employees prior to withdrawal or termination from the Cooperative shall remain in effect for the period stated within the policy issued to the covered individual and cease upon the expiration date stated in said policy.

12. Notice. All notices hereunder shall be in writing and shall be delivered or sent by registered or certified mail, postage prepaid, return receipt requested, or by recognized overnight courier to the Cooperative at the Address of the Administrator set forth below and to the Member at its address shown on the Cooperative's records.

13. Reapplication. A Member who withdraws from the Cooperative or whose membership is terminated may not reapply for membership in the Cooperative for a period of three years from the effective date of such withdrawal or termination.

14. General. This Agreement shall be construed under and governed by the laws of the Commonwealth of Massachusetts and is being executed as an instrument under seal. This Agreement may not be assigned by the Member without the prior written consent of the Cooperative. Failure of either party to enforce a right under this Agreement shall not

act as a waiver of that right or the ability to later assert that right relative to the particular situation involved or to terminate this Agreement arising out of any subsequent default or breach. Headings included herein are for convenience only, and shall not be used to construe this Agreement.

ON THE BASIS of the foregoing, the undersigned Member applied for membership in the Cooperative and agrees to be bound hereby if accepted as a Member in the Cooperative.

Company: ____

Contact: ____

Signature/Title: ______________________________________

Date: ____

(RAMHIC Use Only)
This membership is accepted and the foregoing is agreed to as of this ____ day of ______________.

Retailers Association of Massachusetts Health Insurance Cooperative

BY: ____

QUALIFIED ASSOCIATION MEMBERSHIP VERIFICATION FORM

Company Name: ____

Doing Business As *(if applicable)*: ____

Address: ____

City/Town: ______________________ **State:** _____ **ZIP Code:** ____________

Contact: ____

Phone: ______________________ **Email:** ______________________

Affiliated Qualified Association:

☐ Retailers Association of Massachusetts ☐ Massachusetts Package Store Association

It is understood that membership in one of the aforementioned associations is required to obtain health insurance coverage from the Retailers Association of Massachusetts Health Insurance Cooperative. I hereby certify that the business listed above is a current member of the association indicated on this form.

Signed: ____

Date: ____

Name *(please print)*: ____

RAM MEMBERSHIP APPLICATION

RETAILERS ASSOCIATION OF MASSACHUSETTS

18 Tremont Street, Suite 810
Boston, Massachusetts 02108

CONTACT INFORMATION [Please Print]

BUSINESS NAME | DBA (IF APPLICABLE)

MAILING ADDRESS | CITY & STATE | ZIP

FIRST NAME | LAST NAME

TITLE | EMAIL

PHONE | FAX

BUSINESS WEBSITE | FEDERAL TAX ID NUMBER*

BUSINESS STREET ADDRESS (if different from above) | CITY & STATE | ZIP

BUSINESS INFORMATION

PLEASE INDICATE TYPE OF BUSINESS

NUMBER OF LOCATIONS IN MA | NUMBER OF EMPLOYEES IN MA

BROKER

AGENCY NAME | PHONE

BUSINESS STREET ADDRESS | CITY & STATE | ZIP

PAYMENT TYPE

❏ Check Enclosed (please make payable to Retailers Association of Massachusetts)

❏ Visa ❏ Mastercard ❏ AMEX

CARD # | EXPIRATION DATE

SIGNATURE

COVE RISK POLICY NUMBER

MEMBERSHIP DUES

NEW MEMBER

First Year Dues:	$50
Second Year Dues:	$125

THIRD YEAR & BEYOND

Third year and beyond: Suggested annual dues based on gross sales amount in Massachusetts. Minimum required $175.

GROSS SALES	DUES
Up to $500,000	$175
$500,000 - 1,000,000	$225
$1,000,000 - 1,500,000	$275
$1,500,000 - 2,500,000	$500
$2,500,000 - 5,000,000	$1,000
$5,000,000 - 7,500,000	$1,500
$7,500,000 - 10,000,000	$2,000
Over $10,000,000	$2,000

+ $1,000 per additional $10M in sales

www.retailersma.org

❏ I have read this application, and I understand my membership dues are not predicated on being accepted for any membership service or program and are not refundable. I also understand that my membership is subject to approval by the RAM Board of Directors and if at any time my business fails to meet the criteria of a Regular or Associate Member, my membership in the Retailers Association of Massachusetts and my participation in membership services is subject to termination.

SIGNATURE - OWNER OF BUSINESS | DATE

v.COVE-42018

Massachusetts Package Stores Association, Inc.

30 Lyman St., Suite 2
Westborough, MA 01581
Phone: (800) 322-1383 Fax: (508) 366-1104
E-mail: info@masspack.org

BILL TO:

2019 MEMBERSHIP APPLICATION / INVOICE

TERMS: PAYABLE UPON RECEIPT EFFECTIVE MEMBERSHIP DATE: January - December 2019

MassPack Federal ID #04 1590893

Please review the below categories carefully as important changes have been made to our fee structure. Annual Membership Dues are now based on store size which is determined by # of Full Time Employees/ or the stores weekly payroll hours. Select the appropriate category for each store you are joining.

ANNUAL MASSPACK MEMBERSHIP	**# of stores**		**Total**
Level A = 10 + Full Time Employees (400+ weekly payroll hrs per store)	______	x $399.00 =	$_________
Level B = 5 - 9 Full Time Employees (201 - 399 wkly payroll hrs per store)	______	x $349.00 =	$_________
Level C = < 5 Full Time Employees (199 or less wkly payroll hrs per store)	______	x $325.00 =	$_________

MEMBERSHIP FEE SUB TOTAL $_________

VOLUNTARY CONTRIBUTIONS (Please add any voluntary contribution to your total below.)

_____$500 _____ $300 _____ $100 ____OTHER

TOTAL AMOUNT PAID $__________

Store #1 Name: ____________________________________Contact:_____________________ Phone: __________________

Street: _______________________________________ City: _____________________ Zip: __________Level (circle1): A B C

Primary Email: ____

This email will be used for your communications and as your log-in for the Members Only section of our website.

Store #2 Name: ____________________________________ Contact:_____________________ Phone:__________________

Street: _______________________________________ City: ______________________ Zip: _________ Level (circle1): A B C

Primary Email: ____

This email will be used for your communications and as your log-in for the Members Only section of our website.

Important: We ask that you please list all your stores. You may list additional stores on back if necessary.

Please make checks payable to: Massachusetts Package Stores Association. To pay by credit or debit card, please contact our office at (800)322-1383 or you may fill out the "Charge Information" below.

Charge Card#_____________________________________ Exp. Date: ______________ Charge Amt: $_____________

Name on Card: _________________________________ Card Address: _______________________________________

Signature: ____Today's Date:__________________

PLEASE NOTE: 40% of dues for The Massachusetts Package Stores Association ARE NOT deductible neither as a business expense nor as a charitable contribution. 60% of dues are deductible as a business expense in accordance with IRC Section 6033.

(OVER)

Please list information below for additional stores.

Store #3 Name: ____________________________________ Contact:______________________ Phone:___________________

Street: ____ City: _______________________ Zip: _________ Level (circle1): A B C

Primary Store Email: ____

Store #4 Name: ____________________________________ Contact:______________________ Phone:___________________

Street: ____ City: _______________________ Zip: _________ Level (circle1): A B C

Primary Store Email: ____

Store #5 Name: ____________________________________ Contact:______________________ Phone:___________________

Street: ____ City: _______________________ Zip: _________ Level (circle1): A B C

Primary Store Email: ____

Store #6 Name: ____________________________________ Contact:______________________ Phone:___________________

Street: ____ City: _______________________ Zip: _________ Level (circle1): A B C

Primary Store Email: ____

Member Response Requested

1. **Please tell us the MassPack programs or discounts which you currently utilize or participate in.**

_____ CheckWriter's Payroll

_____ RAM-HIC Health Insurance

_____ Discounted Beverage Alcohol Training

_____ WB Mason Discount bags and supplies

_____ First Data Credit Card Processing

_____ Workers Compensation

2. **We are continually looking to improve our association and its benefits to members. Please let us know how we can help better serve you or if there are other discounts/programs that you'd like to see offered.**

____

____

3. **I am interested in serving on the Board of Directors or volunteering for a MassPack Committee (check here) ______**

Your Name: ____ Best # to reach you: _________________________________

Thank you!