

Name of Tufts Health Plan subscriber: \_\_\_\_\_ Tufts Health Plan Policy ID number: \_\_\_\_\_

## SECTION 1 – EMPLOYMENT STATUS

**Are you or your spouse actively working?** (If YES, please complete the employment information.)

Tufts Health Plan policy holder: NO \_\_\_ YES \_\_\_ Employer \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Spouse: NO \_\_\_ YES \_\_\_ Employer \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

**Have you or your spouse retired?** (If YES, please complete the retirement and former employer information.)

Tufts Health Plan policy holder : NO \_\_\_ YES \_\_\_ Retirement Date \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_

Spouse: NO \_\_\_ YES \_\_\_ Retirement Date \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_

**Do you, your spouse, or children receive Social Security benefits as a result of a disability?**

Tufts Health Plan policy holder: NO \_\_\_ YES \_\_\_ Date of Disability \_\_\_/\_\_\_/\_\_\_

Spouse: NO \_\_\_ YES \_\_\_ Date of Disability \_\_\_/\_\_\_/\_\_\_

Children: Name \_\_\_\_\_ NO \_\_\_ YES \_\_\_ Date of Disability \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_ NO \_\_\_ YES \_\_\_ Date of Disability \_\_\_/\_\_\_/\_\_\_

## SECTION 2 – MEDICARE

**Are you, your spouse or children covered by Medicare?**

Tufts Health Plan policy holder: NO \_\_\_ YES \_\_\_ (If YES, refer to your Medicare card to complete)

Spouse: NO \_\_\_ YES \_\_\_ (If YES, refer to your Medicare card to complete)

Children: NO \_\_\_ YES \_\_\_ (If YES, refer to your Medicare card to complete)

Name of Cardholder	Medicare ID#	Effective Dates	Medicare Entitlement Reason (check)
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure

## SECTION 3—OTHER HEALTH INSURANCE

**At this time or at any time in the last 12 months, are/were any members covered under your Tufts Health Plan policy, including yourself, your spouse or children, also covered by any other health insurance plan?**

If YES, please refer to the *other* insurance card to complete this section. If NO, please proceed to Section 4.

**Other Health Insurance company name** \_\_\_\_\_ Company Phone (\_\_\_\_) \_\_\_\_\_

Effective Date: \_\_\_\_\_ Group # \_\_\_\_\_ Member ID # \_\_\_\_\_

Name of person holding other insurance: \_\_\_\_\_ Date of Birth of other policy holder: \_\_\_\_\_

**Does this other insurance cover you, your spouse or children?**

Tufts Health Plan policy holder: NO \_\_\_ YES \_\_\_

Spouse: NO \_\_\_ YES \_\_\_

Children: NO \_\_\_ YES \_\_\_

## SECTION 4—AUTHORIZATION

Name of person completing this form (please print): \_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge:

Signature: \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

E-mail address: \_\_\_\_\_

***Please return this form to us at Tufts Health Plan COB, P.O. Box 9165, Watertown, MA 02471. Thank you!***