

MEMBER ENROLLMENT FORM

Please print or type. Please be sure application is completed in full to ensure enrollment.

No one does more to keep you healthy.

Enrollment/Eligibility • PO Box 9186 • Watertown, Massachusetts 02471-9186

Employer Section

FAILURE TO COMPLETE AREAS MARKED IN BLUE MAY CAUSE A DELAY IN ENROLLMENT.

1. Name of Employer or Group		2. Group Number		3. Date of Hire		4. Effective Date of Coverage	
5. Office Location		6. Type of Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> New Group <input type="checkbox"/> Qualifying Event (MUST specify) _____				7. Qualifying Event Date	

Member Section

PRODUCT (Select corresponding letter from the list on the front page) _____ **Other** _____
 Have you or anyone in your household used tobacco products, e.g., cigarettes, chewing tobacco, etc., in the last 12 months? Yes No

8. Last Name		9. First Name			10. Middle Initial	11. Employee Social Security Number (SSN) (required)		
12. Mailing Address (Home address)		13. Apt#	14. City		15. State	16. ZIP	17. Gender <input type="checkbox"/> M <input type="checkbox"/> F	18. Date of Birth / month / day / year
19. Home Telephone ()		20. Work Telephone ()		21. Fitness Center			22. Primary Language	
23. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner				24. Type of Coverage Requested <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other _____				
25. Primary Care Provider (HMO, POS, EPO only) First Name Last Name				26. PCP ID#		27. Are you an established patient of this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Members Enrolling (Last name, if different)	Sex M/F	Date of Birth	If dependent is over age 19, please check one		Social Security Number	Fitness Center	Choose a Primary Care Provider for each member (HMO/POS/EPO only)		Check if currently used for primary care	PCP ID#
			Full time Student	Disabled			First Name	Last Name		
28. Spouse/DP					- -					
29. Child/Dependent					- -					
30. Child/Dependent					- -					
31. Child/Dependent					- -					
32. Child/Dependent					- -					
33. Child/Dependent					- -					

34. Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? <input type="checkbox"/> Yes <input type="checkbox"/> Yes (Medicare) <input type="checkbox"/> No		Name of Health Plan	Name of Plan Holder	Health Plan Number	Effective Date	Names of Family Members Covered		
35. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name and Address of Employer _____								
36. Please check if you are using additional membership applications for additional dependent children. <input type="checkbox"/>								

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payment directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the member services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature (required): _____ Date: _____ Benefits Dept. Signature: _____ Telephone: _____ Date: _____