

GROUP INFORMATION		REASON FOR TRANSACTION	
GROUP NUMBER	GROUP NAME	<b>ADDING COVERAGE</b> <input type="checkbox"/> New hire <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (explain in "Remarks" section below)	<b>CHANGES TO EXISTING COVERAGE</b> Change to: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other <input type="checkbox"/> Addition of a dependent (complete "Dependent" section below) <input type="checkbox"/> Change in name, address, or other application information (give previous information in "Remarks" section below) <input type="checkbox"/> Other (explain in "Remarks" section below)
REQUESTED EFFECTIVE DATE	TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER _____	<b>ENDING COVERAGE</b> <input type="checkbox"/> Termination of employment <input type="checkbox"/> Change to other insurance (give name of other insurance in "Remarks" section below) <input type="checkbox"/> Other (explain in "Remarks" section below)	

EMPLOYEE INFORMATION										IF WE MAY CONTACT YOU BY E-MAIL, PLEASE SUPPLY ADDRESS WHERE INDICATED.*																								
NAME (LAST/FIRST/MI)					MAIDEN NAME (IF APPLICABLE)					PRIMARY LANGUAGE					BIRTH DATE					SEX <input type="checkbox"/> M <input type="checkbox"/> F					FCHP IDENTIFICATION NUMBER									
RACE (OPTIONAL) CODE: <input type="checkbox"/> WHITE (10) <input type="checkbox"/> BLACK (20) <input type="checkbox"/> HISPANIC (30) <input type="checkbox"/> ASIAN/PACIFIC ISLANDER (40) <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE (50) <input type="checkbox"/> OTHER (60)										*E-MAIL																								
STREET ADDRESS										CITY					STATE					ZIP CODE					HOME PHONE ( )					SOCIAL SECURITY NUMBER				
WORK PHONE ( )					DATE HIRED					AVERAGE NO. HOURS WORKED					DEPARTMENT #					EMPLOYEE #					IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO					IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: MO DAY YR				
PLEASE WRITE IN YOUR PRIMARY CARE PHYSICIAN SELECTION										EVER TREATED BY THIS PHYSICIAN? (IF YES, UNDER WHAT NAME?) <input type="checkbox"/> YES _____ <input type="checkbox"/> NO										PHYSICIAN CODE					MEDICAL RECORD NUMBER									

DEPENDENT INFORMATION							PRIMARY CARE PHYSICIAN (PCP) SELECTION (SEE PROVIDER LIST)		EVER TREATED BY THIS DOCTOR?		FOR FCHP USE ONLY – MEDICAL RECORD NUMBER	
NAME (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)	BIRTHDATE	RELATION	SOCIAL SECURITY NUMBER	PRIMARY LANGUAGE	RACE	*E-MAIL	PCP SELECTION	YES	NO	PHYSICIAN CODE	LOCATION CODE	
	MO DAY YR	SPOUSE <input type="checkbox"/> M <input type="checkbox"/> F			CODE:		PCP SELECTION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	M.R.		
	MO DAY YR	CHILD <input type="checkbox"/> M <input type="checkbox"/> F					PCP SELECTION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	P.C.	L.C.	
	MO DAY YR	CHILD <input type="checkbox"/> M <input type="checkbox"/> F					PCP SELECTION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	M.R.		
	MO DAY YR	CHILD <input type="checkbox"/> M <input type="checkbox"/> F					PCP SELECTION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	P.C.	L.C.	
	MO DAY YR	CHILD <input type="checkbox"/> M <input type="checkbox"/> F					PCP SELECTION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	M.R.		
	MO DAY YR	CHILD <input type="checkbox"/> M <input type="checkbox"/> F					PCP SELECTION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	P.C.	L.C.	

REMARKS				AGREEMENT			
				I, the undersigned, am employed by the above named company working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage. I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the Fallon Community Health Plan coverage I have selected. I understand that FCHP is a health maintenance organization and that membership becomes effective in accordance with the FCHP Group Agreement and the <i>FCHP Select Care Member Handbook/Evidence of Coverage</i> . I have read the back of this Membership Transaction Form and understand how to obtain and use services under my FCHP coverage. I certify that all information is correct to the best of my knowledge.			
FOR FCHP USE ONLY	REASON CODE	TERRITORY	RECEIPT DATE	EMPLOYEE'S SIGNATURE	DATE	EMPLOYER'S SIGNATURE	DATE
	A T						

## temporary membership card

**WELCOME TO FALLON COMMUNITY HEALTH PLAN!** Thank you for choosing Fallon Community Health Plan for your health coverage. In a short time you will receive a New Member Kit in the mail. This kit will include information on your membership in Fallon Community Health Plan and your membership card(s). In the meantime, this sheet is your **temporary membership card**. Also included in this kit will be an *FCHP Select Care Member Handbook/Evidence of Coverage*, which defines your benefits and governs benefit decisions. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the FCHP Group Agreement and the *FCHP Select Care Member Handbook/Evidence of Coverage*.

**SELECT CARE:** With FCHP Select Care, you have access to an already expansive health care network with thousands of providers from Palmer to Cambridge, Gloucester to Quincy and places in between. Our providers are carefully chosen for their medical excellence and patient access, as well as their efficiency and innovation.

**CHOOSING YOUR PHYSICIAN:** At the time of enrollment, you also must select a primary care physician for every person covered under this contract: a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to [www.fchp.org](http://www.fchp.org) or your *FCHP Select Care Provider Network* directory for a complete list of providers and their locations. You must make these selections now and list your choices on this Membership Transaction Form. If you wish to notify us of a physician change or if you need help choosing a physician, please call the Customer Service Department at 800-868-5200 (TDD/TTY: 877-608-7677).

**MAKING APPOINTMENTS:** Call your doctor's office or medical center directly to schedule appointments.

**EMERGENCY CARE:** *Emergency services do not require referral or authorization.* When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). If you receive care outside of the plan service area, Fallon Community Health Plan requires you to notify the plan within 48 hours or as soon as is medically possible. For more information on emergency benefits and plan procedures for emergency services, consult your *FCHP Select Care Member Handbook/Evidence of Coverage*.

**OUT-OF-AREA CARE:** When you are out of the service area, you are covered for any unexpected illness or injury that needs prompt medical attention. Call FCHP Customer Service at 800-868-5200 (TDD/TTY: 877-608-7677) to report use of services, and call your doctor to arrange for follow-up care.

**REMEMBER:** FCHP will not pay for any services that are not provided or appropriately arranged by Fallon Community Health Plan, except in life-threatening emergencies in the service area or any emergencies out of the service area.

**CONSENT:** Submission of this form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, care services programs, quality management, coordination of care, health services management, accreditation, and processing and payment of related claims.

**QUESTIONS ABOUT COVERAGE?** Call FCHP Customer Service at 800-868-5200 (TDD/TTY: 877-608-7677), or visit our Web site at [www.fchp.org](http://www.fchp.org).

\*Specialty care providers include physicians, physician assistants, nurse practitioners and nurse midwives.