

MEMBER ENROLLMENT FORM

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

PLEASE RETURN THIS COMPLETED FORM TO YOUR INSURANCE INTERMEDIARY

Intermediary Section

1. SELECT A PLAN TYPE AND BENEFIT LEVEL



- HMO Plans**
- | | | |
|---|--|--|
| <input type="checkbox"/> HMO Premium | <input type="checkbox"/> HMO Basic 25 without prescription | <input type="checkbox"/> Advantage HMO 2000 |
| <input type="checkbox"/> HMO Value | <input type="checkbox"/> HMO Basic 35 | <input type="checkbox"/> HMO Select 20 |
| <input type="checkbox"/> HMO Value without prescription | <input type="checkbox"/> HMO Basic 50 | <input type="checkbox"/> Advantage HMO Select 750 |
| <input type="checkbox"/> HMO Basic 20 | <input type="checkbox"/> Advantage HMO 1000 | <input type="checkbox"/> Advantage HMO Select 1000 |
| <input type="checkbox"/> HMO Basic 25 | <input type="checkbox"/> Advantage HMO 1000 without prescription | |

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

4. Employer Group Name		5. Date of Hire		PPO Plans <input type="checkbox"/> Advantage PPO		2. Name of Intermediary		3. Intermediary Group Number	
6. Effective Date of Coverage		7. Office Location		8. Type of Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event (MUST specify)		<input type="checkbox"/> COBRA or COC <input type="checkbox"/> New Group <input type="checkbox"/> New Individual		9. Qualifying Event Date	

Member Section		10. Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Nature of Business with SIC code (if applicable)		12. Name of Business		13. Have you or anyone in your family used tobacco products, e.g., cigarettes, chewing tobacco, etc., in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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14. Last Name			15. First Name			16. Middle Initial	17. Social Security Number (SSN)		
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18. Mailing Address (Home address)		19. Apt#	20. City		21. State	22. ZIP		23. Gender <input type="checkbox"/> M <input type="checkbox"/> F		24. Date of Birth / / month day year	
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25. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced				26. Type of Coverage Requested <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other _____							
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27. Primary Care Physician (HMO only)				28. PCP ID#				29. Check if currently used for primary care <input type="checkbox"/>			
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30. Home Telephone ()			31. Work Telephone ()			32. Fitness Center			33. Primary Language		
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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	DO NOT WRITE IN THIS SPACE	Choose a Primary Care Physician for each member (HMO only)	Tufts Health Plan Affiliated Hospital	Check if currently used for primary care	PCP ID#
			Full-time Student	Disabled							
34. Spouse					- -						
35. Child/Dependent					- -						
36. Child/Dependent					- -						
37. Child/Dependent					- -						
38. Child/Dependent					- -						
39. Child/Dependent					- -						

40. 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	
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41. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, Name and Address of Employer								
42. 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. If this is group coverage, 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 (or 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: _____
(if applicable)