MEMBER ENROLLMENT FORM

TUFTS Health Plan

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186

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

EMPLOYER SECTION

Group/Company Name_____ **Group Number**_____

Office Location_____ **Date of Hire**_____ **Effective Date of Coverage**_____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify)_____ **Qualifying Event Date**_____

MEMBER SECTION

PRODUCT (Select corresponding letter from the list on the front page) _____ Other _____

Last Name_____ **First Name**_____ **Middle Initial**_____ **Primary Language**_____

Employee Social Security Number (required)___-___-_____ **Date of Birth (MM/DD/YYYY)**_____/_____/_____ **Gender:** ❑ Male ❑ Female

Mailing (Home) Address_____ **City**_____ **State**_____ **ZIP**_____ **Home Telephone** (____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner **Type of Coverage Requested:** ❑ Individual ❑ Family ❑ Other_____ **Work Telephone** (____) _____

Primary Care Provider (HMO, POS, EPO only) First Name_____ Last Name_____ **PCP ID#** _____ **Are you an established patient of this PCP?** ❑ Yes ❑ No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number	Choose a Primary Care Provider for each member (HMO, POS, EPO only. Include first and last name.)	Check if currently used for primary care	PCP ID #
❑ Spouse ❑ Domestic Partner			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	

Please check if you are using additional membership applications for additional dependent children. ❑

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? ❑ Yes ❑ Yes **(Medicare)** ❑ No

Name of Health Plan_____ **Name of Plan Holder**_____ **Health Plan Number**_____ **Effective Date**_____

Names of Family Members Covered_____ **Is Spouse Employed?** ❑ Yes ❑ No If Yes, Name and Address of Employer _____

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 payments 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**_____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.