

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 family 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)			
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. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner				20. Type of Coverage Requested <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other _____					
21. Primary Care Physician (HMO, POS, EPO only)				22. PCP ID#		23. Check if currently used for primary care <input type="checkbox"/>			
24. Home Telephone ()		25. Work Telephone ()			26. Fitness Center		27. Primary Language		

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/POS/EPO only)	Tufts Health Plan Affiliated Hospital	Check if currently used for primary care	PCP ID#
			Full time Student	Disabled							
28. Spouse					- -						
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											
37. Does spouse or dependent have different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide permanent address:											
			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 (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: _____

WHITE - TUFTS HEALTH PLAN COPY

PINK - EMPLOYER COPY

YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.