MEMBER ENROLLMENT FORM

No one does more to keep you healthy.

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

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 ☐ New Hire ☐ Open Enrollment ☐ COBRA ☐ New Group ☐ 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 ☐ M ☐ F | 18. Date of Birth month / day / year

19. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner

20. Type of Coverage Requested ☐ Individual ☐ Family ☐ Other _____________

21. Primary Care Physician (HMO, POS, EPO only) | 22. PCP ID# | 23. Check if currently used for primary care ☐

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: Full time Student	Disabled	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#
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? ☐ Yes ☐ Yes (Medicare) ☐ No

Name of Health Plan	Name of Plan Holder	Health Plan Number	Effective Date	Names of Family Members Covered

35. Is spouse employed? ☐ Yes ☐ No If yes, Name and Address of Employer

36. Please check If you are using additional membership applications for additional dependent children ☐

37. Does spouse or dependent have different address? ☐ Yes ☐ No If YES, please provide permanent address:

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.