Health New England
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healthnewengland.org
Phone: (413) 787-4000 | (800) 842-4464 | Enrollment Fax (413) 233-2635

ENROLLMENT/ADD/TERMINATION FORM

PLEASE PRINT AND/OR TYPE INFORMATION. PRINT TO SIGN.

TYPE OF PLAN: ☐ HMO ☐ PPO ☐ GROUP MEDICARE SUPPLEMENT

CLEAR FORM

EMPLOYEE NAME (FIRST, LAST)	COMPANY NAME	PLAN
PRIMARY CARE PROVIDER (PCP) (REQUIRED FOR HMO PLANS)	(PCP) PROVIDER ID# (REQUIRED FOR HMO PLANS)	IS THIS YOUR DOCTOR NOW? ☐ YES ☐ NO
SS# (REQUIRED)	DOB MONTH DAY YEAR	GENDER ☐ MALE ☐ FEMALE
ADDRESS STREET	APT NO.	P.O. BOX
CITY STATE	ZIP	
TELEPHONE (HOME) ( )	TELEPHONE (WORK) ( )	EMAIL
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER	PRIMARY LANGUAGE SPOKEN	
ETHNICITY (use codes from back of form) 1ST	2ND	OTHER / RACE (Use codes from back of form)

WILL ANYONE COVERED ON THIS POLICY KEEP OTHER HEALTH INSURANCE? ☐ YES ☐ NO

NAME OF INSURANCE CO. _____ POLICY #_____

NAMES OF COVERED INDIVIDUALS _____

IS EMPLOYEE RETIRED? ☐ YES RETIREMENT DATE _____ ☐ NO

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE?* ☐ YES ☐ NO

IF YES, ☐ PART A ☐ PART B INCLUDE COPY OF MEDICARE CARD

MEDICARE CLAIM # _____

**If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

FOR GROUP MEDICARE SUPPLEMENT MEMBERS: WILL THIS POLICY REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE CURRENTLY IN FORCE? ☐ YES ☐ NO

DEPENDENT NAME(S) FIRST LAST (IF NOT SAME AS EMPLOYEE)	ETHNICITY (SEE REVERSE)	RACE (SEE REVERSE)	LANGUAGE (SEE REVERSE)	DATE OF BIRTH MO DAY YR	GENDER M F	SOCIAL SECURITY # (REQUIRED)	PCP NAME (REQUIRED FOR HMO PLANS) FIRST LAST	PROVIDER ID#	IS THIS YOUR DOCTOR NOW? Y N
☐ SPOUSE ☐ OTHER				- -		- -			
				- -		- -			
				- -		- -			
				- -		- -			

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, HEALTH NEW ENGLAND AND ANY HEALTH CARE PROVIDER MAY RECEIVE, USE AND DISCLOSE MY MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND ANY AND ALL OTHER USES ALLOWED BY LAW. I HAVE READ AND UNDERSTAND THE TERMS OF ENROLLMENT ON THE BACK OF THIS FORM. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Ⓧ _____

EMPLOYEE SIGNATURE DATE

BELOW SECTION TO BE COMPLETED BY EMPLOYER

EFFECTIVE DATE _____ (new enroll choose qualifying event below)

☐ **TERM POLICY** ☐ **TERM DEPENDENT** **END DATE** _____

☐ **NEW ENROLLMENT** ☐ **ADD DEPENDENT** ☐ **CHANGE MEMBER INFO**

CHOOSE REASON:

☐ **NEW HIRE** (DATE OF HIRE REQUIRED) ☐ **LOSS OF INSURANCE** ☐ **ANNUAL OE** **OTHER** _____ (SPECIFY)

CHOOSE REASON:

☐ **LEFT EMPLOYMENT** ☐ **MOVED** ☐ **VOLUNTARY CANCEL**

☐ **COBRA TERM** ☐ **NO LONGER ELIGIBLE** ☐ **DECEASED**

☐ **TRANSFER TO COBRA**

CHOOSE ONE: ☐ **HNE COBRA** ☐ **HNE COBRA WITH HEALTH EQUITY HRA**

TYPE OF COVERAGE: ☐ **INDIVIDUAL** ☐ **FAMILY** ☐ **EE+1** ☐ **OTHER**

DATE OF HIRE: _____ **HNE GROUP #:** ☐☐☐☐☐☐ — ☐☐☐☐

Ⓧ _____

EMPLOYER SIGNATURE DATE