

MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE FORM WILL CAUSE A DELAY IN ENROLLMENT.

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

EMPLOYER SECTION PLEASE WRITE IN YOUR 8 DIGIT GROUP NUMBER BELOW

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 _____

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

Last Name _____ First Name _____ Middle Initial _____

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

Residential Address (required) _____ City _____ State _____ ZIP _____

P.O. Box (optional) _____ City _____ State _____ ZIP _____

Email Address _____ Home/Work Telephone (_____) _____ Cell Phone (_____) _____ Primary Language _____

Marital Status: Single Married Divorced Domestic Partner Type of Coverage Requested: Individual Family Other _____

Primary Care Provider First Name _____ Last Name _____ PCP/ NPI # _____ Is this your current PCP? Yes No

Members Enrolling First Name / Last Name (if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (Include first and last name.)	Check if currently used for primary care	PCP NPI #
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	

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.

Subscriber Signature _____ Date _____ Employer Signature (required) _____ Telephone _____ Date _____