

Member Transaction Form

Please print clearly and complete all applicable fields.



Fallon Health
Fallon Health & Life Assurance Co., Inc.

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE EMPLOYER:

Group number	Group name <i>Town of Clinton</i>	Effective date: (MM/DD/YYYY)
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Please check off the reason you are filling out this form:

Adding coverage: New hire Annual open enrollment Other (Please explain in the Remarks section below.)

Ending coverage:
 Termination of employment Change to other insurance (Please provide the name of the other insurance in the Remarks section below.)
 Other (Please explain in the Remarks section below.)

Changes to existing coverage: (Please choose an option and explain in the Remarks section below.)

Change to: Individual plan Family plan COBRA Other

Addition of a dependent (Please complete the dependent section of this form.) Date of qualifying event: _____
 Removal of a dependent
 Change in name, address or other application information
 Other

Remarks:

This form is not complete without an authorized employer signature on page 2.

THE FOLLOWING SECTIONS ARE TO BE FILLED OUT BY THE EMPLOYEE (subscriber):

Please complete all applicable fields in this section.

Provider network: Direct Care* Select Care Fallon Preferred Care Steward Community Care* Tiered Choice*

Plan name: *Town of Clinton*

First name	Middle initial (MI)	Last name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Maiden name	Primary language	Birth date (MM/DD/YYYY)
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Street address

City	State	ZIP code
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Mailing address (if different from street above)

City	State	ZIP code
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Would you be interested in receiving communications from Fallon via email? If so, please check the box and provide your email address: <input type="checkbox"/>	Home phone
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Social Security #**	Date hired (MM/DD/YYYY)	Work phone
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Race (please choose one) White Black Hispanic Asian/Pacific Islander American Indian/Alaskan Native Other

Work status (please choose one) Full-time Part-time Retired COBRA

Average # of hours worked weekly	Department #	Employee #
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Does your spouse have health insurance from another source? Yes No

Please provide the name of your selected primary care provider (PCP). Is this your current PCP? Yes No

First name	MI	Last name
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Benefits administrator: Please mail the white and yellow copies of this form to: Fallon Health Service Operations, 10 Chestnut St., Worcester, MA 01608.

The pink copy is for the employee.

DEPENDENT SECTION:

In this section, please list all dependents covered under this plan. If you need more room, please use an additional Member Transaction Form.

Dependent 1: First name			MI	Last name (include maiden name if applicable)		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relation to you				Social Security #**				
Primary language			Race		Birth date (MM/DD/YYYY)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No								
First name			MI	Last name				
Dependent 2: First name			MI	Last name (include maiden name if applicable)		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relation to you				Social Security #**				
Primary language			Race		Birth date (MM/DD/YYYY)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No								
First name			MI	Last name				
Dependent 3: First name			MI	Last name (include maiden name if applicable)		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relation to you				Social Security #**				
Primary language			Race		Birth date (MM/DD/YYYY)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No								
First name			MI	Last name				
Dependent 4: First name			MI	Last name (include maiden name if applicable)		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relation to you				Social Security #**				
Primary language			Race		Birth date (MM/DD/YYYY)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No								
First name			MI	Last name				
Dependent 5: First name			MI	Last name (include maiden name if applicable)		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relation to you				Social Security #**				
Primary language			Race		Birth date (MM/DD/YYYY)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No								
First name			MI	Last name				

I understand that my signature below means that I have read and I understand the contents of this form, and that I agree to the terms and conditions located on the back of this form.

X _____
Employee signature (REQUIRED) Print name here Date

X _____
Employer signature (REQUIRED) Print name here Date

Group name (please print) _____

* Direct Care, Steward Community Care and Tiered Choice provide access to networks that are smaller than the Select Care network. In these plans, members have access to network benefits only from the providers in their respective network. Please consult the respective provider directory—paper copies can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care, Steward Community Care and Tiered Choice.

Tiered Choice members have access to network benefits only from the providers in Tiered Choice, and may pay different levels of copayments, coinsurance and/or deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on January 1.

**Required for tax purposes