MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE AREAS MARKED IN BLUE 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

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 _____

MEMBER SECTION

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

Last Name _____ First Name _____ Middle Initial _____ Primary Language _____

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

Mailing (Home) Address _____ City _____ State _____ ZIP _____

Email Address _____ Home Telephone (____) _____ Work Telephone (____) _____

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

Primary Care Provider First Name _____ Last Name _____ PCP ID# _____ Are you an established patient of this PCP? ❑ Yes ❑ No

Members Enrolling (First name, include 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 ID #
❑ Spouse ❑ Domestic Partner			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	

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.

Signature _____ Date _____ Benefits Dept. Signature (required) _____ Telephone _____ Date _____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.