

Fallon Community Health Plan Employer Group Membership Transaction Form



Please complete all fields on form. (Please print clearly.)

PLEASE CHOOSE YOUR PROVIDER NETWORK

FCHP DIRECT CARE FCHP SELECT CARE Plan name (if applicable): Rate Saver -

EMPLOYEE INFORMATION IF WE MAY CONTACT YOU BY E-MAIL, PLEASE SUPPLY ADDRESS WHERE INDICATED.*

NAME (LAST, FIRST, MI)			MAIDEN NAME (IF APPLICABLE)		PRIMARY LANGUAGE
STREET ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE ()
BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> OTHER			
WORK PHONE ()	*E-MAIL	SOCIAL SECURITY NO.		STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA	
DATE HIRED	AVERAGE NO. HOURS WORKED	DEPARTMENT #	EMPLOYEE #	IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIMARY CARE PHYSICIAN SELECTION
EVER TREATED BY THIS PHYSICIAN? (IF YES, UNDER WHAT NAME?) <input type="checkbox"/> NO <input type="checkbox"/> YES			IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: MO / DAY / YR		

DEPENDENT INFORMATION

PRIMARY CARE PHYSICIAN (PCP) SEE PROVIDER LIST

NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL			RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL			RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL			RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL			RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL			RACE	

GROUP INFORMATION

REASON FOR TRANSACTION

GROUP NUMBER <u>5550</u>	ADDING COVERAGE <input type="checkbox"/> New hire <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (explain in "Remarks" section below)	CHANGES TO EXISTING COVERAGE Change to: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other <input type="checkbox"/> Addition of a dependent (complete "Dependent" section above) <input type="checkbox"/> Change in name, address, or other application information (give previous information in "Remarks" section below) <input type="checkbox"/> COBRA <input type="checkbox"/> Other (explain in "Remarks" section below)
GROUP NAME <u>WSHG WALPOLE</u>	ENDING COVERAGE <input type="checkbox"/> Termination of employment <input type="checkbox"/> Change to other insurance (give name of other insurance in "Remarks" section below) <input type="checkbox"/> Other (explain in "Remarks" section below)	
REQUESTED EFFECTIVE DATE		
TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER		

REMARKS

AGREEMENT (SUBSCRIBER'S SIGNATURE)

I agree to the terms and conditions located on the back of this form.
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For FCHP Use Only	Territory	Receipt Date	Employer's Signature	Date
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