

MEMBER ENROLLMENT FORM

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Enrollment/Eligibility • PO Box 9186 • Watertown, Massachusetts 02471-9186

FAILURE TO COMPLETE AREAS MARKED IN BLUE WILL CAUSE A DELAY IN ENROLLMENT.

EMPLOYER SECTION

Group/Company Name WSHG. WALPOLE

Group Number 41130-18

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) P Other _____

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

Primary Language _____

Employee Social Security Number (required) _____

Gender: Male Female

Mailing (Home) Address _____

State _____ ZIP _____

Home Telephone (____) _____

Marital Status: Single Married Divorced Domestic Partner

Type of Coverage Requested: Individual Family Other _____

Work Telephone (____) _____

Primary Care Provider (HMO, POS, EPO only) 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	If dependent is age 19 or over, please check one			Social Security Number	Choose a Primary Care Provider for each member (HMO, POS, EPO only. Include first and last name)	Check if currently used for primary care	PCP ID #
				Full time student	Disabled	IRS Dependent				
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- -		<input type="checkbox"/>	
Child/Dependent				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- -		<input type="checkbox"/>	
Child/Dependent				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- -		<input type="checkbox"/>	
Child/Dependent				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- -		<input type="checkbox"/>	
Child/Dependent				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- -		<input type="checkbox"/>	
Child/Dependent				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- -		<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 No (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 (required) _____ Date _____ Benefits Dept. Signature _____ Telephone _____ Date _____

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