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): ______________________________

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 ❑ M ❑ F	RACE ❑ WHITE ❑ BLACK ❑ HISPANIC ❑ ASIAN/PACIFIC ISLANDER ❑ AMERICAN INDIAN/ALASKAN NATIVE ❑ OTHER			SOCIAL SECURITY NO.
WORK PHONE ( )		*E-MAIL			DATE HIRED
AVERAGE NO. HOURS WORKED	DEPARTMENT #	EMPLOYEE #	IS YOUR SPOUSE EMPLOYED? ❑ YES ❑ NO	IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: MO / DAY / YR	
PRIMARY CARE PHYSICIAN SELECTION		EVER TREATED BY THIS PHYSICIAN? (IF YES, UNDER WHAT NAME?) ❑ YES ______ ❑ NO		LOCATION CODE NUMBER	PHYSICIAN CODE NUMBER

DEPENDENT INFORMATION

DEPENDENT INFORMATION			PRIMARY CARE PHYSICIAN (PCP) SEE PROVIDER LIST	FCHP USE ONLY
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION	LOCATION CODE NUMBER
RELATION ______	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO	PHYSICIAN CODE NUMBER
*E-MAIL		RACE ______		
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION	LOCATION CODE NUMBER
RELATION ______	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO	PHYSICIAN CODE NUMBER
*E-MAIL		RACE ______		
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION	LOCATION CODE NUMBER
RELATION ______	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO	PHYSICIAN CODE NUMBER
*E-MAIL		RACE ______		
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION	LOCATION CODE NUMBER
RELATION ______	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO	PHYSICIAN CODE NUMBER
*E-MAIL		RACE ______		
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION	LOCATION CODE NUMBER
RELATION ______	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO	PHYSICIAN CODE NUMBER
*E-MAIL		RACE ______		

GROUP INFORMATION

GROUP NUMBER

GROUP NAME

REQUESTED EFFECTIVE DATE

TYPE OF COVERAGE
- ❑ INDIVIDUAL ❑ FAMILY
- ❑ OTHER ______________

REASON FOR TRANSACTION

ADDING COVERAGE
- ❑ New hire
- ❑ Annual open enrollment
- ❑ Other (explain in "Remarks" section below)

ENDING COVERAGE
- ❑ Termination of employment
- ❑ Change to other insurance (give name of other insurance in "Remarks" section below)
- ❑ Other (explain in "Remarks" section below)

CHANGES TO EXISTING COVERAGE

Change to:
- ❑ Individual ❑ Family ❑ Other
- ❑ Addition of a dependent (complete "Dependent" section above)
- ❑ Change in name, address, or other application information (give previous information in "Remarks" section below)
- ❑ COBRA
- ❑ Other (explain in "Remarks" section below)

REMARKS

AGREEMENT (SUBSCRIBER'S SIGNATURE)

I agree to the terms and conditions located on the back of this form.

X ______________________________

For FCHP Use Only	Territory	Receipt Date	Employer's Signature	Date

Benefits Administrator: Mail white and yellow copies to FCHP Service Operations, 10 Chestnut St., Worcester, MA 01608. Pink copy is for employee.
FCHP cannot process this form without authorized signature from employer.

Temporary Membership Card

WELCOME! Thank you for choosing Fallon Community Health Plan (FCHP) for your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information on your membership in FCHP and your membership card(s). In the meantime, this sheet is your **temporary membership card.** Also included in this kit will be information on how to obtain a *Member Handbook/Evidence of Coverage*, which defines your benefits and regulates benefit decisions. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the FCHP Group Agreement and the FCHP Direct Care or FCHP Select Care *Member Handbook/Evidence of Coverage*.

CHOOSING YOUR PHYSICIAN: At the time of enrollment, you also must select a primary care physician for every person covered under this contract: a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to fchp.org or your FCHP Direct Care or FCHP Select Care *Provider Network* directory for a complete list of providers and their locations. You must make these selections now and list your choices on this Membership Transaction Form. If you wish to notify us of a physician change or if you need help choosing a physician, please call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). To make an appointment, call your doctor's office or medical center directly.

EMERGENCY CARE: *Emergency services do not require referral or authorization.* When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). If you receive care outside of the plan service area, Fallon Community Health Plan requires you to notify the plan within 48 hours or as soon as is medically possible. For more information on emergency benefits and plan procedures for emergency services, consult your *Member Handbook/Evidence of Coverage*.

OUT-OF-AREA CARE: When you are out of the service area, you are covered for any unexpected illness or injury that needs prompt medical attention. Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) to report use of services, and call your doctor to arrange for follow-up care.

REMEMBER: FCHP will not pay for any services that are not provided or appropriately arranged by Fallon Community Health Plan, except in life-threatening emergencies in the area or any emergencies out of the service area.

CONSENT: Submission of this form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation, processing and payment of related claims.

AGREEMENT: I am employed by the company named on this form, working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage (or I am otherwise eligible for the named company's health insurance coverage, e.g., as a former employee covered under COBRA). I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the FCHP coverage I have selected. I understand that FCHP is a health maintenance organization and that membership becomes effective in accordance with the FCHP Group Agreement and the *Member Handbook/Evidence of Coverage*. I have read this Membership Transaction Form and understand how to obtain and use services under my FCHP coverage. I certify that all information is correct to the best of my knowledge.

QUESTIONS ABOUT COVERAGE? Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or visit our Web site at fchp.org.