WELCOME TO TUFTS HEALTH PLAN

New Members—Register at Tuftshealthplan.com for Fast Access to Your Personal Benefit Information.

Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card and member benefit document soon. Need a temporary ID? Use the yellow copy of this completed form.

Member Sections

- **Personal Information:** Complete all enrollment information. If your plan (HMO, POS, or EPO) requires the selection of a primary care provider (PCP), be sure to fill out this section for all members, including dependents.
- **Product Code:** Please be sure to fill in the correct product code for the plan you have selected.
- **Primary Care Provider:** It is important that you choose a PCP right away, if your plan requires one. Without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com, and use the Doctor Search feature. In Box 22 of this application, indicate whether you are an established patient of the PCP you have listed. You are an established patient if you have seen the PCP routinely in the past for your health care. If you are selecting a new PCP, contact the doctor right away, introduce yourself as a new member, and find out if your doctor would like to schedule a physical exam. Transfer your medical records to your new PCP right away.
- **Students/Dependents/Children:** If you have a student/dependent/child enrolling on your plan—age 19 and over (if your employer is based in Rhode Island) or 21 and over if your employer is based in Massachusetts (this may be 19 and over with some employers)—you must certify their status on initial enrollment and again as requested by Tufts Health Plan. Student/dependent/child forms can be obtained and submitted at www.tuftshealthplan.com.
- **Other Health Coverage:** If you have other insurance (including Medicare), please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the No box.

Employer Section

Your employer must fill out this section.

When the Application is Complete

- Employee keeps the yellow copy (also your temporary ID)
- Employer keeps the pink copy
- Tufts Health Plan receives the original white copy

  Tufts Health Plan
  P.O. Box 9186
  Watertown, MA 02471-9186

If You Need Emergency Care

In an emergency, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP, if your plan requires one.

Please Note

By enrolling, you agree to and understand that if you or any of your enrolled dependents obtain a health care benefit or payment that you know you are not entitled to receive or be paid or if you knowingly present or cause to be presented with fraudulent intent a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation.

Tufts Health Plan arranges for the provision of health care services but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Product Codes

Write the corresponding letter in the product box in the member section of the enrollment application.

A - HMO Premium
B - HMO Value
C - HMO Basic
D - HMO Choice Copay
E - Advantage HMO
F - Advantage HMO with HRA
G - Advantage HMO Saver
H - POS
I - POS Choice Copay
J - EPO
K - EPO Choice Copay
L - PPO
M - Advantage PPO
N - Advantage PPO with HRA
O - Advantage PPO Saver
P - Navigator by Tufts Health Plan
Q - Carelink
R - HMO Select 10
S - HMO Select 20
T - Advantage HMO Select 750
U - Advantage HMO Select 2000
V - Advantage HMO Select Young Adult
W - Rhode Island Healthpact
RIC - Rhode Island Conversion

We speak 140 languages. Call for translation services:

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl
យើង និយាយ ភាសាខ្មែរ

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the doctor search feature. If you need help filling out this form, call a member services coordinator at 1-800-462-0224.

18079-5/09

TUFTS Health Plan
No one does more to keep you healthy.

MEMBER ENROLLMENT FORM

Please print or type. Please be sure application is completed in full to ensure enrollment.

Enrollment/Eligibility • PO Box 9186 • Watertown, Massachusetts 02471-9186

TUFTS Health Plan
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Employer Section

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

1. Name of Employer or Group	2. Group Number	3. Date of Hire	4. Effective Date of Coverage
5. Office Location	6. Type of Enrollment: New Hire Open Enrollment COBRA New Group Qualifying Event (MUST specify)_____		7. Qualifying Event Date

Member Section

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

Have you or anyone in your household used tobacco products, e.g., cigarettes, chewing tobacco, etc., in the last 12 months? Yes No

8. Last Name	9. First Name	10. Middle Initial	11. Employee Social Security Number (SSN) (required)

12. Mailing Address	13. Apt#	14. City	15. State	16. ZIP	17. Gender M F	18. Date of Birth month / day / year

19. Home Telephone ( )	20. Work Telephone ( )	21. Fitness Center	22. Primary Language

23. Marital Status Single Married Divorced Domestic Partner	24. Type of Coverage Requested Individual Family Other

25. Primary Care Provider (HMO, POS, EPO only) First Name Last Name	26. PCP ID#	27. Are you an established patient of this PCP? Yes No

Members Enrolling (Last name, if different)	Sex M/F	Date of Birth	If dependent is over age 19, please check one: Full time Student	Disabled	Social Security Number	Fitness Center	Choose a **Primary Care Provider** for each member (HMO/POS/EPO only)	Check if currently used for primary care	PCP ID#
28. Spouse/DP					- -		First Name Last Name	☐	
29. Child/Dependent					- -			☐	
30. Child/Dependent					- -			☐	
31. Child/Dependent					- -			☐	
32. Child/Dependent					- -			☐	
33. Child/Dependent					- -			☐	

34. 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

35. Is spouse employed? Yes No If yes, Name and Address of Employer

36. Please check if you are using additional membership applications for additional dependent children.

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 payment 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.