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			
WORK PHONE ( )	*E-MAIL	SOCIAL SECURITY NO.	STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ COBRA		
DATE HIRED	AVERAGE NO. HOURS WORKED	DEPARTMENT #	EMPLOYEE #	IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO	PRIMARY CARE PHYSICIAN SELECTION
EVER TREATED BY THIS PHYSICIAN? ☐ NO (IF YES, UNDER WHAT NAME?) ☐ 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) ☐ M ☐ F		SOCIAL SECURITY NO.	PCP SELECTION
RELATION _____	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ☐ YES ☐ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE) ☐ M ☐ F		SOCIAL SECURITY NO.	PCP SELECTION
RELATION _____	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ☐ YES ☐ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE) ☐ M ☐ F		SOCIAL SECURITY NO.	PCP SELECTION
RELATION _____	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ☐ YES ☐ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE) ☐ M ☐ F		SOCIAL SECURITY NO.	PCP SELECTION
RELATION _____	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ☐ YES ☐ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE) ☐ M ☐ F		SOCIAL SECURITY NO.	PCP SELECTION
RELATION _____	BIRTHDATE MO / DAY / YEAR	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ☐ YES ☐ NO
*E-MAIL		RACE	

GROUP INFORMATION

GROUP NUMBER 5550391

GROUP NAME TOWN OF DEDHAM

REQUESTED EFFECTIVE DATE 07-01-12

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.