

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 <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 5550334	ADDING COVERAGE <input type="checkbox"/> New hire <input checked="" type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (explain in "Remarks" section below) 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)	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 TOWN OF DEDHAM		
REQUESTED EFFECTIVE DATE 07-01-12		
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.	
		X _____	
For FCHP Use Only	Territory	Receipt Date	Employer's Signature
			Date