

# 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 TOWN OF DEDHAM Group Number 41330-020  
 Office Location \_\_\_\_\_ Date of Hire \_\_\_\_\_ Effective Date of Coverage 07-01-12  
 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) \_\_\_\_\_ Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Primary Language \_\_\_\_\_  
 Employee Social Security Number (required) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female  
 Mailing (Home) Address \_\_\_\_\_ City \_\_\_\_\_ 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  Yes (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 \_\_\_\_\_