WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

New Members — Register at Tuftshealthplan.com for fast access to your secure online account and personal benefit information.

Please fill in the "employee" sections of this membership application completely. Failure to do so could delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon. If you need a temporary ID, please use the yellow copy of this completed form.

Employer Section

Your employer must fill out this section.

Employee Section

- Personal Information: Complete all enrollment information. For all plans, select 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: If your plan requires you to choose a PCP, it is important that you select one right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are an established patient of the PCP you have listed. (You are an established patient if you have routinely received health care services from this provider in the past.) If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam. You will then need to transfer your medical records to your new PCP.
- Other Health Coverage: If you have other or additional insurance (such as Medicare), please check the correct box and fill in the requested information. If you do not have any other insurance, be sure to check the "No" box.

When the Application is Complete

- Give the application to your employer.
- Employee keeps the yellow copy. This is also your temporary ID.
- Employer keeps the pink copy.
- Employer mails the original white copy to:
  Tufts Health Plan
  P.O. Box 9186
  Watertown, MA 02471-9186

If You Need Emergency Care

If a health care emergency occurs, 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.

Notices

By enrolling, you understand and agree that if you or any of your enrolled dependents obtain a health care benefit or payment that you are not entitled to receive, or if you knowingly present 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 the cost of the investigation.

Tufts Health Plan arranges for the provision of health care services 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. Tufts Health Plan does not directly provide health care services.

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
G - Advantage HMO Saver
H - POS
I - POS Choice Copay
J - EPO
K - EPO Choice Copay
L - PPO
M - Advantage PPO
O - Advantage PPO Saver
P - Navigator by Tufts Health Plan
Q - Carelink
R - Select HMO
S - Select Advantage HMO
T - Rhode Island Healthpact
U - Your Choice HMO
V - Your Choice PPO
W - Steward Community Choice
LPC - Lifespan Premier Choice

We speak 140 languages.
Call Member 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
เรือ อิตาย ภาษาไทย

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 Specialist.

Member Services:

800.462.0224

COM-30100003-092015 18079

MEMBER ENROLLMENT FORM

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

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186

EMPLOYER SECTION

Group/Company Name Town of Dedham - School Group Number High Deductible 57527-020

Office Location _____ Date of Hire _____ Effective Date of Coverage _____

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 _____

Email Address _____ Home Telephone (_____) _____ Work Telephone (_____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Family ❑ Other _____

Primary Care Provider 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 (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (Include first and last name.)	Check if currently used for primary care	PCP ID #
❑ Spouse ❑ Domestic Partner XXXXXXXXXXXX			___ - ___ -		☐	
Child/Dependent			___ - ___ -		☐	
Child/Dependent			___ - ___ -		☐	
Child/Dependent			___ - ___ -		☐	
Child/Dependent			___ - ___ -		☐	
Child/Dependent			___ - ___ -		☐	

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 _____ Date _____ Benefits Dept. Signature (required) _____ Telephone _____ Date _____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.