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 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. On this application you will 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.
- **Student/Child Dependents:** If you have a student/child dependent enrolling on your plan (age 19 and over in Rhode Island; 19 or 21 and over in Massachusetts, depending on employer) you must certify their status on initial enrollment and again as requested by Tufts Health Plan. Dependent certification forms can be obtained and submitted at 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.

Notices

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 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.

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 - HMO Select 15

S - HMO Select 20

T - Advantage HMO Select 750

U - Advantage HMO Select 2000

W - Rhode Island Healthpact

RIC - Rhode Island Conversion

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 tiềng 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 specialist.

Member Services:

1-800-462-0224

18079-1/10

MEMBER ENROLLMENT FORM

TUFTS Health Plan

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________________________________ **Group Number**________________________________

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**_________ **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				
❑ Spouse ❑ Domestic Partner			❑	❑	❑	- -		❑	
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 (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.