BOSTON MEDICAL CENTER HEALTHNet PLAN

HSAinsurance

Individual Enrollment Form

Enrollee information

Enrollee name (first and last) ______________________ DOB __/__/__ Sex ☐ M ☐ F

Enrollee address ______________________ Apt # ______ SSN ___ - ___ - ___

City ______________________ State ______ ZIP ______

Billing address ______________________ Apt # ______

City ______________________ State ______ ZIP ______

Email ______________________ Primary language ______

Phone number ______________________ Requested effective date __/__/__

Primary care provider (PCP) name ______________________ PCP ID # ______ Existing patient ☐ Yes ☐ No

If the PCP you select is not in our network, we will select a PCP we think is right for you. You may change your PCP at any time.

Coverage type (select one)

☐ Self ☐ Individual/Spouse ☐ Individual/Child or children ☐ Family

Please select the plan in which you wish to enroll:

☐ *Silver A*

☐ *Silver B*

Please provide **ALL** information below for any eligible dependents you wish to enroll. You can use additional enrollment forms if you need more room:

Spouse name (first and last) ______________________

DOB __/__/__ Sex ☐ M ☐ F SSN ___ - ___ - ___ IRS dependent ☐ Yes ☐ No

PCP name ______________________ PCP ID # ______ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ______________________

DOB __/__/__ Sex ☐ M ☐ F SSN ___ - ___ - ___ IRS dependent ☐ Yes ☐ No

PCP name ______________________ PCP ID # ______ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ______________________

DOB __/__/__ Sex ☐ M ☐ F SSN ___ - ___ - ___ IRS dependent ☐ Yes ☐ No

PCP name ______________________ PCP ID # ______ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ______________________

DOB __/__/__ Sex ☐ M ☐ F SSN ___ - ___ - ___ IRS dependent ☐ Yes ☐ No

PCP name ______________________ PCP ID # ______ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ______________________

DOB __/__/__ Sex ☐ M ☐ F SSN ___ - ___ - ___ IRS dependent ☐ Yes ☐ No

PCP name ______________________ PCP ID # ______ Existing patient ☐ Yes ☐ No

FORM CONTINUED ON BACK
PLEASE COMPLETE BOTH SIDES

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Disclosures

1. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
2. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
3. Payments not received by the 10th of the month are subject to a late fee, currently $25.
4. Payments not received by the 20th of the month are subject to a pending termination fee, currently $50.
5. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier. Reinstatements are subject to a reinstatement fee, currently $50.
6. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $20.
7. HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.
8. Once bound, the decision to rescind or retroactively terminate coverage is in the carrier's sole discretion.

The information supplied on this form is true and complete. I assign benefits to BMC HealthNet Plan for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan, or other coverage. I agree that BMC HealthNet Plan and its providers may obtain and/or release my/our medical information to administer benefits, evaluate medical care provided, conduct quality assurance reviews and analysis, conduct medical research, and/or as required by law. I understand that for BMC HealthNet Plan coverage to be in effect, all care, supplies, and services must be authorized, and/or provided by in-network providers.

You must be a Massachusetts resident to enroll in this health plan. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include but are not limited to being liable for the full amount of health care benefits or payments made, termination of coverage or fines.

ALL INFORMATION MUST BE COMPLETED AND SIGNED BEFORE PROCESSING CAN BEGIN.

____ Date ___ /___ /___

Broker name______________________________ Broker Address______________________________