Massachusetts Employee Enrollment & Change Form

HSA, 135 Wood Rd, Braintree, MA 02184
P: 781-848-4950 **F:** 781-848-7020
hsainsurance.com

PLEASE PRINT AND/OR TYPE INFORMATION. PRINT TO SIGN.

EMPLOYEE INFORMATION

Employee Name *(First, Last)*: Company Name:

Address: City: State: Zip:

Social Security *(required)*: DOB *(mm/dd/year)*: / / Gender: ☐ M ☐ F

Phone *(Home)*: Phone *(Work)*:

Email: Primary Language Spoken: Race:

Ethnicity 1st *(optional)*: 2nd: Other:

Type of Plan: ☐ HMO ☐ PPO **Type of Coverage:** ☐ Individual ☐ EE+Dependent(s) ☐ EE+Spouse ☐ Family

Name of Plan: Primary Care Provider-PCP[1]:

Provider ID/NPI#[1]: Is this your PCP now? ☐ Yes ☐ No

1 *Required for HMO enrollees, 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.*

ELIGIBLE DEPENDENT(s) INFORMATION

Dependent 1

First Name: Last Name: DOB *(mm/dd/year)*: / /

Social Security *(required)*: Gender: ☐ M ☐ F Relationship to Employee:

Primary Care Provider-PCP[1]: Provider ID/NPI #[1]: Is this your PCP now? ☐ Yes ☐ No

Dependent 2

First Name: Last Name: DOB *(mm/dd/year)*: / /

Social Security *(required)*: Gender: ☐ M ☐ F Relationship to Employee:

Primary Care Provider-PCP[1]: Provider ID/NPI #[1]: Is this your PCP now? ☐ Yes ☐ No

Dependent 3

First Name: Last Name: DOB *(mm/dd/year)*: / /

Social Security *(required)*: Gender: ☐ M ☐ F Relationship to Employee:

Primary Care Provider-PCP[1]: Provider ID/NPI #[1]: Is this your PCP now? ☐ Yes ☐ No

Dependent 4

First Name: Last Name: DOB *(mm/dd/year)*: / /

Social Security *(required)*: Gender: ☐ M ☐ F Relationship to Employee:

Primary Care Provider-PCP[1]:	Provider ID/NPI #[1]:	Is this your PCP now? ☐ Yes ☐ No

1 Required for HMO enrollees, 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.

OTHER INFORMATION

Will anyone covered on this policy keep other health insurance? ☐ Yes ☐ No

If yes, name of insurance company:	Policy Number:
Names of covered individuals:	
Is employee retired? ☐ Yes Retirement Date: / /	☐ No
Are you or any of your dependents covered by Medicare?* ☐ Yes ☐ No	If yes, ☐ Medicare Part A ☐ Medicare Part B *Include a copy of Medicare Card*
Medicare Claim #:	For group Medicare supplement members: will this policy replace any other accident and sickness insurance currently in force? ☐ Yes ☐ No

**If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, MINUTEMAN HEALTH AND ANY HEALTH CARE PROVIDER MAY RECEIVE, USE AND DISCLOSE MY MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND ANY AND ALL OTHER USES ALLOWED BY LAW. TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION ON THIS FORM IS CORRECT AND COMPLETE. I UNDERSTAND THAT ANY FRAUD OR MATERIAL MISREPRESENTATION CONTAINED HEREIN MAY VOID COVERAGE AND MAY LEAD TO OTHER PENALTIES UNDER APPLICABLE LAW.

Employee Signature **Date**

EMPLOYER SECTION

Effective Date: / / **Date of Hire:** / /

Type of Change: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Event *(see below)* ☐ Term Policy ☐ Term Dependent ☐ Update/Change Member Info

Qualifying Event: ☐ Add Dependent ☐ Loss of Insurance ☐ Other ☐ Transfer to COBRA ☐ Left Employment ☐ Moved ☐ Voluntary Cancel ☐ COBRA Term ☐ No Longer Eligible ☐ Deceased

Employer Signature **Date**

MHI Group #