# Massachusetts Individual 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.

## ENROLLEE INFORMATION

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

**Qualifying Event:** ☐ Add Dependent ☐ Loss of Insurance ☐ Other ☐ Moved ☐ Voluntary Cancel
☐ No Longer Eligible ☐ Deceased

Enrollee Name *(First, Last)*: Requested Effective Date: / /

Address: City: State: Zip:

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

Phone *(Home)*: Phone *(Mobile)*: Are you a resident of Massachusetts? ☐ Yes ☐ No

Email: Primary Language Spoken: Race:

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

Primary Care Provider-PCP[1]:

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

***1*** *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.*

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

### PLEASE SELECT AN HMO PLAN BELOW

| | | | |
|---|---|---|---|
| ☐ MyDoc Simple Care** | ☐ MyDoc Gold Basic | ☐ MyDoc Silver Basic | ☐ MyDoc Bronze 1750 |
| ☐ MyDoc Platinum Basic | ☐ MyDoc Gold Plus | ☐ MyDoc Silver Plus | ☐ MyDoc Bronze 2500 |
| ☐ MyDoc Platinum Extra Value | ☐ MyDoc Gold 1500 | ☐ MyDoc Sliver 1750 | ☐ MyDoc Bronze Standard |
| ☐ Other:_____ | | ☐ MyDoc Sliver Basic 2050 | ☐ MyDoc Bronze HAS 3400 |

**MyDoc HMO Simple Care meets the federal definition of a "Catastrophic Plan" and as such is only available to certain qualified individuals. You are eligible to enroll in MyDoc Simple Care if you and each of your benefits eligible dependents: (1) Are under the age of age 30 prior to the first day of the Policy Year OR (2) Have received a certification that you are exempt from the federal requirement to buy health insurance (the "individual Mandate").

**Please contact Minuteman Health directly for additional plans that may not be listed on this application**

## ELIGIBLE DEPENDENT(s) INFORMATION

**Dependent 1**

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

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

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 Enrollee:

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 Enrollee:

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 Enrollee:

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

***1*** *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.*

To the best of my knowledge and belief, the information supplied on this form is true and complete. I agree that Minuteman Health 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 permitted by state and federal law. I understand that MHI's authorization to disclose personal health information shall remain valid for no more than 24 months. I understand that for Minuteman Health coverage to be in effect, all care, supplies, and services must be authorized, and/or provided by in-network providers. I represent, to the best of my knowledge, that all information on this form is correct and complete. No alteration of any written application for insurance, by erasure, insertion or otherwise, shall be made by any person other than me without my written consent, and the making of any such alteration without my consent shall be a misdemeanor. I understand that any fraud or material misrepresentation contained herein may void coverage and may lead to other penalties under applicable law.

**Enrollee Signature** **Print Name** **Date**

**Broker Name** *(if applicable)* **Date**

Broker Address City State Zip

Phone Email