TUFTS Health Plan

Health Services Administrators
Insurance Benefits Made Easy

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:

☐ *Direct Platinum*
☐ *Direct Gold 750 w/Coins*
☐ *Direct Gold 1000*
☐ *Direct Silver 2000*
☐ *Direct Silver 2500 w/Coins*
☐ *Direct Bronze 2500*
☐ *Direct Bronze 3500 w/Coins*
☐ *Direct Catastrophic*

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

The information supplied on this form is true and complete. I assign benefits to Tufts Health 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 Tufts Health 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 Tufts Health 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.

Signature ____________________ Date __/__/__

Broker name ____________________ Broker Address ____________________