TUFTS Health Plan

HSAinsurance

Individual Enrollment Form
Tufts Health Direct

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:

2019 Plans:

- ☐ *Direct Platinum*
- ☐ *Direct Gold 1000*
- ☐ *Direct Gold 2000*
- ☐ *Direct Silver 2000*
- ☐ *Direct Silver 2500 w/Coins*
- ☐ *Direct Bronze 2750*
- ☐ *Direct Bronze 3500 w/Coins*
- ☐ *Direct Catastrophic*

2020 Plans:

- ☐ *Direct Platinum*
- ☐ *Direct Gold 1000*
- ☐ *Direct Gold 2000*
- ☐ *Direct Silver 2000*
- ☐ *Direct Silver 2500 w/Coins*
- ☐ *Direct Silver 2000 HSA*
- ☐ *Direct Bronze 2900*
- ☐ *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

FORM CONTINUED ON BACK
PLEASE COMPLETE BOTH SIDES

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 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_____