WELCOME TO TUFTS HEALTH PLAN

New Members—Register at Tuftshealthplan.com for fast access to your secure online account and personal benefit information.

Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card and member benefit document soon. Need a temporary ID? Use the yellow copy of this completed form.

Member Sections

- Personal Information: Complete all enrollment information. For all plans, please select a primary care provider (PCP), be sure to fill out this section for all members, including dependents.
- Primary Care Provider: It is important that you choose a PCP right away. Without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the doctor search feature. On this application you will indicate whether you are an established patient of the PCP you have listed. You are an established patient if you have seen the PCP routinely in the past for your health care. If you are selecting a new PCP, contact the doctor right away, introduce yourself as a new member, and find out if your doctor would like to schedule a physical exam. Transfer your medical records to your new PCP right away.
- Dependent Children: Dependent children are covered until their 26th birthday. Please be sure to fill out all appropriate information for each dependent, including primary care provider (if applicable).
- Other Health Coverage: If you have other insurance (including Medicare), please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the No box.

Intermediary Section

This section must be filled out by your insurance intermediary.

When the Application Is Complete

Please return this form to your insurance intermediary.

- Employee keeps the yellow copy (also your temporary ID)
- Employer keeps the pink copy
- Tufts Health Plan and/or your insurance intermediary receives the original white copy

If You Need Emergency Care

In an emergency, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP, if your plan requires one.

Please Note

By enrolling, you agree to and understand that if you or any of your enrolled dependents obtain a health care benefit or payment that you know you are not entitled to receive or be paid, or knowingly present or cause to be presented with fraudulent intent a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation.

Tufts Health Plan arranges for the provision of health care services but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the doctor search feature. If you need help filling out this form, call a member services specialist at 800.462.0224.

We speak 140 languages. Call Member Services.

MEMBER ENROLLMENT FORM

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. **PLEASE RETURN THIS COMPLETED FORM TO YOUR INSURANCE INTERMEDIARY.**

FAILURE TO COMPLETE AREAS MARKED IN BLUE WILL CAUSE A DELAY IN ENROLLMENT.

INTERMEDIARY USE ONLY

Name of Intermediary_____

Intermediary Group Number_____

TUFTS Health Plan

EMPLOYER SECTION

Group/Company Name_____ Group Number_____

Office Location_____ Date of Hire_____ Effective Date of Coverage_____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify)_____ Qualifying Event Date_____

MEMBER SECTION

Last Name_____ First Name_____ Middle Initial_____ Primary Language_____

Employee Social Security Number (required)_____ Date of Birth (MM/DD/YYYY)_____ / _____ / _____ Gender: ❑ Male ❑ Female

Mailing (Home) Address_____ City_____ State_____ ZIP_____

Email Address_____ Home Telephone (_____) _____ Work Telephone (_____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Subscriber & Spouse ❑ Subscriber & Child ❑ Subscriber & Children ❑ Family ❑ Other_____

Primary Care Provider First Name_____ Last Name_____ PCP ID# _____ Are you an established patient of this PCP? ❑ Yes ❑ No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (Include first and last name.)	Check if currently used for primary care	PCP ID #
❑ Spouse ❑ Domestic Partner			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	

Please check if you are using additional membership applications for additional dependent children. ❑

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan_____ Name of Plan Holder_____ Health Plan Number_____ Effective Date_____

Names of Family Members Covered_____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer _____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature_____ Date_____ Benefits Dept. Signature (required)_____ Telephone_____ Date_____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.