



# MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE FORM WILL CAUSE A DELAY IN ENROLLMENT.

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186

**EMPLOYER SECTION** **PLEASE WRITE IN YOUR 8 DIGIT GROUP NUMBER BELOW**

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 \_\_\_\_\_

**SUBSCRIBER SECTION** **PRODUCT (Select corresponding letter from the list on the front page)** \_\_\_\_\_ **Other** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Employee Social Security Number (required) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female

Residential Address (required) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

P.O. Box (optional) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Email Address \_\_\_\_\_ Home/Work Telephone ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Primary Language \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Domestic Partner Type of Coverage Requested:  Individual  Family  Other \_\_\_\_\_

Primary Care Provider First Name \_\_\_\_\_ Last Name \_\_\_\_\_ PCP/ NPI # \_\_\_\_\_ Is this your current PCP?  Yes  No

Members Enrolling First Name / 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 NPI #
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	

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.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_ **Employer Signature** (required) \_\_\_\_\_ Telephone \_\_\_\_\_ Date \_\_\_\_\_

## DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### Tufts Health Plan:

- ▶ Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- ▶ Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tufts Health Plan at 800.462.0224.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

### Tufts Health Plan, Attention:

Civil Rights Coordinator Legal Dept.  
705 Mount Auburn St. Watertown, MA 02472  
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]  
Fax: 617.972.9048  
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201  
800.368.1019, 800.537.7697 (TDD)  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

For no cost translation in English, call the number on your ID card.

**Arabic** للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك.

**Chinese** 若需免費的中文版本，請撥打 ID 卡上的電話號碼。

**French** Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

**German** Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

**Greek** Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτας σας.

**Haitian Creole** Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

**Italian** Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

**Japanese** 日本語の無料翻訳については ID カードに書いてある番号に電話してください。

**Khmer (Cambodian)** សម្រាប់សេវាកម្មប្រយោជន៍ឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

**Korean** 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

**Laotian** ສຳລັບການແປພາສາ ບັນພາສາລາວທີ່ບໍ່ໄດ້ສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

**Navajo** Doo bąąh ilíni da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'é bee née ho' dílzingo nantiniígíí bikáá'.

**Persian.** برای ترجمه رایگا فارسی به شماره تلفن مندرج در کارت شناسایی تان زنگ بزنید.

**Polish** Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

**Portuguese** Para tradução grátis para português, ligue para o número no seu cartão de identificação.

**Russian** Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

**Spanish** Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

**Tagalog** Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

**Vietnamese** Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.



705 Mt Auburn Street - Watertown, MA 02472  
tuftshealthplan.com - 800.462.0224