Health New England
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healthnewengland.org

ENROLLMENT/ADD/TERMINATION FORM

Please print and/or type information. Print to sign.

TYPE OF PLAN: ☐ HMO ☐ PPO ☐ GROUP MEDICARE SUPPLEMENT

EMPLOYER Section (please provide your group and division number below)

Application for Enrollment
- ☐ New Employee
- ☐ Annual Enrollment
- ☐ COBRA Enrollment
- ☐ Loss of Insurance (REASON): _____
- ☐ Other (SPECIFY): _____

Change in Enrollment
- ☐ Termination
- ☐ Adding Dependents
- ☐ Removing Dependents
- ☐ Employee/Dependent Demographics
- ☐ Other (SPECIFY): _____

Reason for Change in Enrollment
- ☐ Marriage
- ☐ Birth of Child
- ☐ Adoption of Child
- ☐ Divorce
- ☐ Left Employment
- ☐ Voluntary
- ☐ Loss of Dependent Eligibility
- ☐ Death
- Date of Death (MM/DD/YYYY): _____ / _____ / _____

Group/Company Name:	Benefit Plan:	Group/Division #: GROUP #: _ _ _ _ _ _ DIVISION # _ _ _ _
Date of Hire (MM/DD/YYYY): _____ / _____ / _____	Effective Date of Coverage (MM/DD/YYYY): _____ / _____ / _____	End Date of Coverage (MM/DD/YYYY): ____ / ____ / _____

HEALTH SAVINGS ACCOUNT (HSA): Applicable for Employer-Sponsored HDHP only.

Are you electing an HSA (REFERENCE PAGE 2): ☐ Yes ☐ No	HSA Effective Date (MM/DD/YYYY): _____ / _____ / _____	Are you a current Health New England member? If yes, Member ID #: _____

EMPLOYEE Section

LAST Name:	FIRST Name:		Middle Initial:
Employee's Social Security Number (REQUIRED): – –	Date of Birth (MM/DD/YYYY): / /	Gender: ☐ Male ☐ Female	
Residential Address (REQUIRED):	City:	State:	Zip:
Mailing Address / P.O. Box:	City:	State:	Zip:
Email Address:	Home / Cell Telephone: ( ) –	Work Telephone: ( ) –	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner	Type of Coverage Requested: ☐ Individual ☐ Family ☐ Other		
Primary Language Spoken:	Ethnicity (ENTER CODE FROM PAGE 2):	Race (ENTER CODE FROM PAGE 2):	

Primary Care Provider (PCP) Information

PCP FIRST Name:	PCP LAST Name:	Health New England (HNE) Provider # (REFERENCE PAGE 2):	Existing PCP? ☐ Yes ☐ No

Dependent Enrolling	FIRST Name / LAST Name (IF DIFFERENT)	Gender (M/F)	Date of Birth (MM/DD/YYYY)	Social Security Number	Choose a PCP for each member (FIRST AND LAST NAME REQUIRED. IF PPO PLAN, THEN PCP CAN BE BLANK).	Existing PCP (Y/N)	HNE Provider # (REFERENCE PAGE 2)
☐ Spouse ☐ Domestic Partner		☐ M ☐ F	/ /	– –		☐ Y ☐ N	
Child/Dependent		☐ M ☐ F	/ /	– –		☐ Y ☐ N	
Child/Dependent		☐ M ☐ F	/ /	– –		☐ Y ☐ N	
Child/Dependent		☐ M ☐ F	/ /	– –		☐ Y ☐ N	
Child/Dependent		☐ M ☐ F	/ /	– –		☐ Y ☐ N	
Child/Dependent		☐ M ☐ F	/ /	– –		☐ Y ☐ N	

Will anyone covered on this policy keep other health insurance? ☐ Yes ☐ No	Name of Insurance Co.:	Policy #:	
Names of Covered Individuals:	First/Last Name:	First/Last Name:	
	First/Last Name:	First/Last Name:	
Are you or any of your dependents covered by Medicare? ☐ Yes ☐ No	Will this policy replace any other accident and sickness insurance currently in force? ☐ Yes ☐ No		

Part A Effective Date (MM/DD/YYYY): _____ / _____ / _____	Part B Effective Date (MM/DD/YYYY): _____ / _____ / _____	Medicare #: _____	Actively Working? ☐ Yes ☐ No	☐ 65+ ☐ Disabled ☐ ESRD If retired, date (MM/DD/YYYY): ___ / ___ / ___

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, HEALTH NEW ENGLAND AND ANY HEALTH CARE PROVIDER MAY RECEIVE, USE AND DISCLOSE MY MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND ANY AND ALL OTHER USES ALLOWED BY LAW. I HAVE READ AND UNDERSTAND THE TERMS OF ENROLLMENT ON THE BACK OF THIS FORM. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

IMPORTANT: All information must be completed and form signed before processing can begin.

Employer Contact FIRST Name (PLEASE PRINT):	Employer Contact LAST Name (PLEASE PRINT):
Employer phone number: ( ) –	Employer email address:
EMPLOYER'S Signature: X	Date (MM/DD/YYYY): _____ / _____ / _____
EMPLOYEE'S Signature: X	Date (MM/DD/YYYY): _____ / _____ / _____

IMPORTANT: Please read these terms of enrollment.

As an employee, I understand that:

1. By submitting this form or accepting coverage under the plan, I agree, on behalf of myself and all enrolled dependents, to abide by the terms of the Health New England Agreement, which includes this form as well as the applicable Explanation of Coverage or Summary Plan Description.
2. Membership will become effective upon acceptance by the Plan and that benefits under the Plan will be explained in a separate document (Explanation of Coverage or Summary Plan Description).
3. I may only enroll dependents subject to the guidelines outlined in my Health New England Agreement.
4. Whenever I seek treatment or services, I must identify myself as a Health New England member by presenting my Health New England Identification Card.
5. I must select a Primary Care Physician for myself and my dependents (does not apply to PPO).
6. If appropriate, I authorize my employer to deduct from my wages the rate required for the coverage selected.

As an employer, I understand that:

1. By submitting this form, I certify that the information provided on this form is accurate.

HOW TO: Find a Health New England Provider Number

Visit **healthnewengland.org** and click on **"Find a Provider"** to access our provider directory or search for your provider's 5-digit provider number.

RACE & ETHNICITY

Why are these questions being asked?

The Commonwealth of Massachusetts has established statewide goals for improving health care quality and reducing racial and ethnic disparities in health care. Health New England wants to do our part to remove any barriers to fair and unbiased treatment for all of our members. By collecting information about your race and ethnic background, we may be able to identify possible issues that affect the care or treatment you receive. Health New England will then be able to work with our provider community to address any issues. We appreciate your assistance in this effort. This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment. Health New England keeps this information confidential according to our policies and state and federal law.

RACE: Please choose from the following. Fill in the code where indicated on the front of this form.

Code	Description	Code	Description	Code	Description
R1	American Indian/Alaska Native	R4	Native Hawaiian or other Pacific Islander	UNKNOWN	Unknown/not specified
R2	Asian	R5	White		
R3	Black/African American	R9	Other Race		

ETHNIC GROUP: Please choose from the following (you may choose more than one). Fill in the code where indicated on the front of this form.

Code	Description	Code	Description	Code	Description
2182-4	Cuban	2029-7	Asian Indian	2158-4	Honduran
2184-0	Dominican	BRAZIL	Brazilian	2039-6	Japanese
2148-5	Mexican American, Chicano	2033-9	Cambodian	2040-4	Korean
2180-8	Puerto Rican	CVERDN	Cape Verdean	2041-2	Laotian
2161-8	Salvadoran	CARIBI	Caribbean Island	2118-8	Middle Eastern
2155-0	Central American (not otherwise specified)	2034-7	Chinese	PORTUG	Portuguese
2165-9	South American (not otherwise specified)	2169-1	Colombian	RUSSIA	Russian
2060-2	African	2108-9	European	EASTEU	Eastern European
2058-6	African American	2036-2	Filipino	2047-9	Vietnamese
AMERCN	American	2157-6	Guatemalan	OTHER	Other Ethnicity
2028-9	Asian	2071-9	Haitian	UNKNOWN	Unknown/not specified

HEALTH SAVINGS ACCOUNT (HSA) AUTHORIZATION

By selecting YES, you agree to the following:

- You are enrolled in a qualified high deductible health plan.
- You have no other health coverage, including Medicare.
- You are not claimed as a tax dependent.
- In compliance with the USA Patriot Act, verification of identity will be performed by the vendor and you may be asked to provide additional information and/or documentation before your account can be established.
- Health New England will send eligibility and claims on your behalf to participating vendor.