WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

Please fill in the "subscriber" sections of this membership application completely so we do not delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon.

Employer Section

Your employer must fill out this section.

Employee Section

- Personal Information: Complete all enrollment information. Please select a primary care provider (PCP). Be sure to fill out this section for all members, including dependents.
- Product Code: Please be sure to fill in the correct product code for the plan you have selected. (Please use chart on the right.)
- **Primary Care Provider: If your plan requires you to choose a PCP, it is important that you select one right away. Until we know who your PCP is, 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, indicate whether you are a current patient of the PCP you have listed. (You are a current patient if you have routinely received health care services from this provider in the past.) If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam.**
- Other Health Coverage: If you have other or additional insurance (such as Medicare), please check the correct box and fill in the requested information. If you do not have any other insurance, be sure to check the "No" box.

When the Application is Complete

- Give the application to your employer.
- Employer mails the form to:
  Tufts Health Plan
  P.O. Box 9186
  Watertown, MA 02471-9186

Notices

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

Tufts Health Plan arranges for the provision of health care services 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. Tufts Health Plan does not directly provide health care services.

We collect email addresses and cell phone numbers ("your information") as part of the registration process. We may use your information to notify you of online activity related to the security and privacy of your accounts, such as, retrievals of username, etc. In addition we may use your information to send you health and wellness information and other updates that might be of interest to you as members of Tufts Health Plan. On certain occasions we may also share your information with providers in our network so that they may send you information that describes health-related products and/or services offered by the provider and included in your plan of benefits, enhancements to your plan, and/or benefits and services available to you as a health plan member that add value to, but are not part of, your plan of benefits. Each time we or any such provider sends health and wellness information and other updates, you will be given the opportunity to opt-out of receiving similar emails or cell phone communications in the future. Please note that you cannot opt-out of receiving emails that notify you of online activity since these are necessary to protect the privacy and security of Web accounts.

Product Codes

Write the corresponding letter in the product box in the subscriber section of the enrollment application.

- **A.** HMO Premium
- **B.** HMO Value
- **C.** HMO Basic
- **D.** HMO Choice Copay
- **E.** Advantage HMO
- **F.** Advantage HMO Saver
- **G.** POS
- **H.** POS Choice Copay
- **I.** EPO
- **J.** EPO Choice Copay
- **K.** PPO
- **L.** Advantage PPO
- **M.** Advantage PPO Saver
- **N.** Navigator by Tufts Health Plan
- **O.** CareLink
- **P.** Select HMO
- **Q.** Select Advantage HMO
- **R.** Rhode Island HEALTHPact
- **S.** Your Choice HMO
- **T.** Your Choice PPO
- **U.** Steward Community Choice
- **LPC.** Lifespan Premier Choice

We speak over 200 languages.
Call Member Services.

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl
เรือ อิชาย ภาสาไธย

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 Representative.

Member Services:

800.462.0224

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 #
❑ 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.

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) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo bąąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian. برای ترجمه رایگا فارسی به شماره تلفن مندرج در کارت شناسائی 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.

TUFTS Health Plan

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