Mass General Brigham
Health Plan

Enrollment and Change Form

399 Revolution Drive, Suite 940, Somerville, MA 02145

Tel 1-866-414-5533
Fax 617-526-1981

Please use a ball point pen and press down firmly.

Application for Enrollment
- ☐ New employee
- ☐ Annual enrollment
- ☐ COBRA Continuation
- ☐ Involuntary loss of prior group coverage*
- ☐ Other ______________

*Documentation required

Change in Enrollment
- ☐ Add dependents
- ☐ Remove dependents
- ☐ PCP/Site change
- ☐ Termination
- ☐ Employee/dependent demographics
- ☐ Other ______________

Reason for Change in Enrollment
- ☐ Marriage
- ☐ Birth of child
- ☐ Adoption of child*
- ☐ Divorce
- ☐ Left employment
- ☐ Reached age 65
- ☐ Add disabled dependents
- ☐ Moved out of service area
- ☐ Voluntary
- ☐ Loss of dependent eligibility
- ☐ Death, exact date ________

Group Information

Mass General Brigham Health Plan group number	Employer name		
Date of employment Month Day Year	Effective Date Month Day Year	Plan design	

Intermediary
- ☐ Group
- ☐ Non-group

Employee Information

Last name		First name		M.I.	
Date of birth (mm/dd/yy)	Social Security Number - -	Gender (m/f/u)	Home phone – include area code	Email address	
Street mailing address	Apt.	P.O. Box	City	State	Zip code

PCP and Site Information

For help finding an in-network PCP, please go to MassGeneralBrighamHealthPlan.org and search our Find a Doctor tool. Then, select the product you are enrolling in from the drop down list. You may change your PCP at any time.

Primary care site	
Your Primary Care Physician (Last name, First, M.I.)	Existing patient? ☐ Yes ☐ No

Language

What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐ English ☐ Spanish ☐ Cantonese ☐ Cape Verdean Creole ☐ French ☐ Haitian Creole ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Vietnamese ☐ Other, please specify______________

Group Coverage

Type of Mass General Brigham Health Plan coverage (check only one) ☐ Self ☐ Individual & spouse ☐ Individual & child/children ☐ Family	In addition to Mass General Brigham Health Plan, my spouse or children are covered by a health plan offered by: Employer	Insurance co. name	Policy #	Effective date

Are you and/ or your spouse eligible for Medicare?	Self ☐ Yes ☐ No	If yes, are you enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your Medicare policy number
	Spouse ☐ Yes ☐ No	If yes, is your spouse enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your spouse's Medicare policy number

Please provide ALL information below for any eligible dependents you wish to enroll.

Spouse last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number - -	Gender (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number - -	Gender (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number - -	Gender (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number - -	Gender (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number - -	Gender (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Acknowledgement: The information supplied on this form is true and complete. I assign benefits to Mass General Brigham 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 (we) agree that Mass General Brigham Health Plan and its affiliated health care providers may obtain or release my (our) medical information including medical records, medical coverage available or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. I (we) understand that for Mass General Brigham Health Plan coverage to be in effect when medical care supplies are obtained, all care and supplies must be authorized and provided by participating care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Asigno (asignmos) beneficios a Mass General Brigham Health Plan por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que Mass General Brigham Health Plan y sus Proveedores de Cuidado de Salud afiliados puenden obtener o divulger mi (nuestra) información médica, incluyendo registros medicos, cobertura médica disponible o otra información médica, con el próposito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica y/o cuando es requerida por la ley. Yo entiendo (entendemos) que para que la cobertura de Mass General Brigham Health Plan tenga vigencia para la obtención de suministros médicos, toda la atención y todos los sumistros deben ser autorizados y proporcionados por un medico de cuidado primario paricipante autorizado (segun se indica arriba).

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

Employee's signature: ______________________ Date: __________

Employer contact name (please print): ______________ Phone: __________ Employer's signature: ______________________ Date: __________

Return white original to Mass General Brigham Health Plan — Yellow copy to employer — Pink copy to employee