Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
(413) 787-4000 | (800) 842-4464 | Fax: (413) 233-2635
healthnewengland.org

# ENROLLMENT/ADD/TERMINATION FORM

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

TYPE OF PLAN: ☐ HMO ☐ PPO

## 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): / / | Sex at Birth:* ☐ Female ☐ Male |
| 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) | Sex at Birth* (F/M) | 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 | | ☐ F ☐ M | / / | – – | | ☐ Y ☐ N | |
| Child/Dependent | | ☐ F ☐ M | / / | – – | | ☐ Y ☐ N | |
| Child/Dependent | | ☐ F ☐ M | / / | – – | | ☐ Y ☐ N | |
| Child/Dependent | | ☐ F ☐ M | / / | – – | | ☐ Y ☐ N | |
| Child/Dependent | | ☐ F ☐ M | / / | – – | | ☐ Y ☐ N | |
| Child/Dependent | | ☐ F ☐ M | / / | – – | | ☐ 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: |
| 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<br>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): _____ / _____ / _____ |

**If you would like to tell us more about your gender identity, please use this secure online form at **bit.ly/sogi-form**. Health New England is committed to making sure every member feels safe, welcome and respected.*

## 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:**

- 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.