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# ENROLLMENT/ADD/TERMINATION FORM

PLEASE PRINT AND/OR TYPE INFORMATION. PRINT TO SIGN.

TYPE OF PLAN:  HMO  PPO  GROUP MEDICARE SUPPLEMENT

**CLEAR FORM**

EMPLOYEE NAME (FIRST, LAST)		COMPANY NAME		PLAN						
PRIMARY CARE PROVIDER (PCP) (REQUIRED FOR HMO PLANS)		(PCP) PROVIDER ID# (REQUIRED FOR HMO PLANS)		IS THIS YOUR DOCTOR NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO						
SS# (REQUIRED)		DOB MONTH DAY YEAR		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE						
ADDRESS STREET		APT NO.		P.O. BOX						
CITY		STATE		ZIP						
TELEPHONE (HOME) ( ) ( )		TELEPHONE (WORK) ( ) ( )		EMAIL						
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER			PRIMARY LANGUAGE SPOKEN							
ETHNICITY (use codes from back of form) 1st		2nd		OTHER						
RACE (Use codes from back of form)										
DEPENDENT NAME(S) FIRST LAST (IF NOT SAME AS EMPLOYEE)		ETHNICITY	RACE	LANGUAGE	DATE OF BIRTH MO DAY YR	GENDER M F	SOCIAL SECURITY # (REQUIRED)	PCP NAME (REQUIRED FOR HMO PLANS) FIRST LAST	PROVIDER ID#	IS THIS YOUR DOCTOR NOW? Y N
<input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER					- -	M F	- -			
					- -	M F	- -			
					- -	M F	- -			
					- -	M F	- -			

WILL ANYONE COVERED ON THIS POLICY KEEP OTHER HEALTH INSURANCE?  YES  NO

NAME OF INSURANCE CO. \_\_\_\_\_ POLICY # \_\_\_\_\_

NAMES OF COVERED INDIVIDUALS \_\_\_\_\_

IS EMPLOYEE RETIRED?  YES RETIREMENT DATE \_\_\_\_\_  NO

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE?\*  YES  NO

IF YES,  PART A  PART B INCLUDE COPY OF MEDICARE CARD

MEDICARE CLAIM # \_\_\_\_\_

*\*If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

FOR GROUP MEDICARE SUPPLEMENT MEMBERS: WILL THIS POLICY REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE CURRENTLY IN FORCE?  YES  NO

**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.**

\_\_\_\_\_  
 EMPLOYEE SIGNATURE DATE

**BELOW SECTION TO BE COMPLETED BY EMPLOYER**

**EFFECTIVE DATE** \_\_\_\_\_ (new enroll choose qualifying event below)

NEW ENROLLMENT  ADD DEPENDENT  CHANGE MEMBER INFO

CHOOSE REASON:  
 NEW HIRE (DATE OF HIRE REQUIRED)  LOSS OF INSURANCE  ANNUAL OE  OTHER \_\_\_\_\_ (SPECIFY)

TRANSFER TO COBRA  
 CHOOSE ONE:  HNE COBRA  HNE COBRA WITH HEALTH EQUITY HRA

**DATE OF HIRE:** \_\_\_\_\_ **HNE GROUP #:**       -

TERM POLICY  TERM DEPENDENT **END DATE** \_\_\_\_\_

CHOOSE REASON:  
 LEFT EMPLOYMENT  MOVED  VOLUNTARY CANCEL  
 COBRA TERM  NO LONGER ELIGIBLE  DECEASED

**TYPE OF COVERAGE:**  INDIVIDUAL  FAMILY  EE+1  OTHER

\_\_\_\_\_  
 EMPLOYER SIGNATURE DATE

## 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 (HNE) 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 HNE Agreement.
4. Whenever I seek treatment or services, I must identify myself as an HNE member by presenting my HNE 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.**

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

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