



Employee Enrollment Form

Employer information

Employer name _____ Group # _____

Employee informationType of Enrollment: New hire Open enrollment COBRA New group Qualifying event: _____

Date of hire ___/___/___ Requested effective Date ___/___/___

Employee name (first and last) _____ DOB ___/___/___ Sex M F

Employee address _____ Apt # _____ SSN _____ - _____ - _____

City _____ State _____ ZIP _____

Email _____ Primary language _____

Home Phone _____ Cell Phone _____ Fax _____

Primary care provider (PCP) name _____ PCP ID # _____ Existing patient Yes No*If the PCP you select is not in our network, we will select a PCP we think is right for you. You may change your PCP at any time.***Coverage type (select one)** Self Individual/Spouse Individual/Child or children FamilyPlease provide **ALL** information below for any eligible dependents you wish to enroll. You can use additional enrollment forms if you need more room:

Spouse name (first and last) _____

DOB ___/___/___ Sex M F SSN _____ - _____ - _____ IRS dependent Yes NoPCP name _____ PCP ID # _____ Existing patient Yes No

Dependent name (first and last) _____

DOB ___/___/___ Sex M F SSN _____ - _____ - _____ IRS dependent Yes NoPCP name _____ PCP ID # _____ Existing patient Yes No

Dependent name (first and last) _____

DOB ___/___/___ Sex M F SSN _____ - _____ - _____ IRS dependent Yes NoPCP name _____ PCP ID # _____ Existing patient Yes No

Dependent name (first and last) _____

DOB ___/___/___ Sex M F SSN _____ - _____ - _____ IRS dependent Yes NoPCP name _____ PCP ID # _____ Existing patient Yes No

Dependent name (first and last) _____

DOB ___/___/___ Sex M F SSN _____ - _____ - _____ IRS dependent Yes NoPCP name _____ PCP ID # _____ Existing patient Yes No

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 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 agree that Tufts Health Plan and its providers may obtain and/or release my/our medical information to administer benefits, evaluate medical care provided, conduct quality assurance reviews and analysis, conduct medical research, and/or as required by law. I understand that for Tufts Health Plan coverage to be in effect, all care, supplies, and services must be authorized, and/or provided by in-network providers.

ALL INFORMATION MUST BE COMPLETED AND SIGNED BEFORE PROCESSING CAN BEGIN.

Signature _____ Date ___/___/___