Minuteman Health

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ENROLLMENT/ADD/TERMINATION FORM

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

EMPLOYEE NAME (FIRST, LAST)	COMPANY NAME	PLAN NAME	WILL ANYONE COVERED ON THIS POLICY KEEP OTHER HEALTH INSURANCE? ☐ YES ☐ NO

PRIMARY CARE PROVIDER (PCP) (REQUIRED)	(PCP) PROVIDER ID# (REQUIRED)	IS THIS YOUR DOCTOR NOW? ☐ YES ☐ NO	NAME OF INSURANCE COMPANY	POLICY NUMBER

SOCIAL SECURITY # (REQUIRED) - -	DOB: MM/DD/YEAR / /	GENDER ☐ Male ☐ Female	NAMES OF COVERED INDIVIDUALS

ADDRESS	APT NO.	P.O. BOX	IS EMPLOYEE RETIRED? ☐ YES RETIREMENT DATE / / ☐ NO

CITY	STATE	ZIP	ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE? * ☐ YES ☐ NO

PHONE (HOME): - -	PHONE (WORK): - -	EMAIL:	IF YES, ☐ PART A ☐ PART B INCLUDE COPY OF MEDICARE CARD

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER	PRIMARY LANGUAGE SPOKEN	RACE	MEDICARE CLAIM #: **If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

ETHNICITY (optional) 1ST	2ND	OTHER	FOR GROUP MEDICARE SUPPLEMENT MEMBERS: WILL THIS POLICY REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE CURRENTLY IN FORCE? ☐ YES ☐ NO

DEPENDENT NAME(S) FIRST LAST (IF NOT SAME AS EMPLOYEE)	RELATIONSHIP TO EMPLOYEE	DOB MM/DD/YY	GENDER	SOCIAL SECURITY # (REQUIRED)	PCP NAME (REQUIRED) FIRST LAST	PROVIDER ID#	IS THIS YOUR DOCTOR NOW?
		/ /	M/F	- -			Y/N
		/ /	M/F	- -			Y/N
		/ /	M/F	- -			Y/N
		/ /	M/F	- -			Y/N

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, MINUTEMAN HEALTH 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 TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION ON THIS FORM IS CORRECT AND COMPLETE.

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** ☐ **LOSS OF INSURANCE** ☐ **ANNUAL OE** ☐ **OTHER**

☐ **TERM POLICY** ☐ **TERM DEPENDENT** **END DATE: / /**

CHOOSE REASON:

☐ **LEFT EMPLOYMENT** ☐ **MOVED** ☐ **VOLUNTARY CANCEL**

☐ **COBRA TERM** ☐ **NO LONGER ELIGIBLE** ☐ **DECEASED**

☐ **TRANSFER TO COBRA**

TYPE OF PLAN: ☐ **HMO** ☐ **PPO** **TYPE OF COVERAGE:** ☐ **INDIVIDUAL** ☐ **FAMILY** ☐ **EE+1** ☐ **OTHER**

DATE OF HIRE: / / **MINUTEMAN GROUP #:** **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 Minuteman Health Agreement, which includes this form as well as the applicable Explanation of Coverage or Summary of 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 of Plan Description)

3. I may only enroll dependents subject to the guidelines outlined in my Agreement.

4. Whenever I seek treatment or services, I must identify myself as a member by presenting my Identification Card.

5. I must select a Primary Care Physician for myself and my dependents.

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:

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION ON THIS FORM IS CORRECT AND COMPLETE. THE GROUP UNDERSTANDS THAT IF IT HAS COMMITTED FRAUD OR MADE A MISREPRESENTATION OF ANY MATERIAL FACT IN CONJUNCTION WITH THIS APPLICATION, MINUTEMAN MAY RETROACTIVELY CANCEL COVERAGE.

RACE & ETHNICITY

Why are these questions being asked?

The Commonwealth of MA has established statewide goals for improving health care quality and reducing racial and ethnic disparities in health care. Minuteman 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. Minuteman 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 to determining eligibility, rating, or claim payment. Minuteman keeps this information confidential according to our policies and state and federal law.