



1 Sundial Ave, Manchester, NH 03103
 Phone: 857-263-8242
 Fax: 857-263-8951
 Minutemanhealth.org

ENROLLMENT/ADD/TERMINATION FORM

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

EMPLOYEE NAME (FIRST, LAST)		COMPANY NAME		PLAN	WILL ANYONE COVERED ON THIS POLICY KEEP OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PRIMARY CARE PROVIDER (PCP) (REQUIRED)	(PCP) PROVIDER ID# (REQUIRED)	IS THIS YOUR DOCTOR NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF INSURANCE COMPANY		POLICY NUMBER	
SOCIAL SECURITY # (REQUIRED) - -	DOB: MM/DD/YEAR / /	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		NAMES OF COVERED INDIVIDUALS			
ADDRESS		APT NO.	P.O. BOX	IS EMPLOYEE RETIRED? <input type="checkbox"/> YES RETIREMENT DATE / / <input type="checkbox"/> NO			
CITY	STATE	ZIP		ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE? * <input type="checkbox"/> YES <input type="checkbox"/> NO			
PHONE (HOME): - -		PHONE (WORK): - -		IF YES, <input type="checkbox"/> PART A <input type="checkbox"/> PART B INCLUDE COPY OF MEDICARE CARD			
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER		PRIMARY LANGUAGE SPOKEN	RACE	MEDICARE CLAIM #: <i>*If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.</i>			
EMAIL:				FOR GROUP MEDICARE SUPPLEMENT MEMBERS: WILL THIS POLICY REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE CURRENTLY IN FORCE? <input type="checkbox"/> YES <input type="checkbox"/> 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)	<input type="checkbox"/> TERM POLICY	<input type="checkbox"/> TERM DEPENDENT	END DATE: / /
<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> CHANGE MEMBER INFO	CHOOSE REASON:		
CHOOSE REASON:	<input type="checkbox"/> LEFT EMPLOYMENT	<input type="checkbox"/> MOVED	<input type="checkbox"/> VOLUNTARY CANCEL
<input type="checkbox"/> NEW HIRE <input type="checkbox"/> LOSS OF INSURANCE <input type="checkbox"/> ANNUAL OE <input type="checkbox"/> OTHER	<input type="checkbox"/> COBRA TERM	<input type="checkbox"/> NO LONGER ELIGIBLE	<input type="checkbox"/> DECEASED
<input type="checkbox"/> TRANSFER TO COBRA			

TYPE OF PLAN: HMO POS

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