TUFTS Health Plan
NETWORK HEALTH

Health Services Administrators
Insurance Benefits Made Easy

Employee Enrollment Form

Employer information

Employer name ________________________________ Group # ____________

Employee information

Type 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 ____________

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.

Tufts Health Plan – Network Health coverage type (select one)

☐ Self ☐ Individual/Spouse ☐ Individual/Child or children ☐ Family

Please 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 ☐ No

PCP name ________________________ PCP ID # ____________ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ________________________

DOB ___/___/___ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name ________________________ PCP ID # ____________ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ________________________

DOB ___/___/___ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name ________________________ PCP ID # ____________ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ________________________

DOB ___/___/___ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name ________________________ PCP ID # ____________ Existing patient ☐ Yes ☐ No

Dependent name (first and last) ________________________

DOB ___/___/___ Sex ☐ M ☐ F SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP 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 – Network Health coverage. I assign benefits to Tufts Health Plan – Network Health 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 – Network Health 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 – Network Health 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 ___/___/___