Corporate Office
135 Wood Road
Braintree, MA 02184
781.848.4950

New Case Submission Checklist

HEALTH NEW ENGLAND
Individual Application

To ensure your application is processed as quickly and accurately as possible, follow these steps:

1.	The **Individual** completes and signs the **Individual Application** and chooses a plan	☐
2.	Enclose a copy of **Proposal/Quote** showing rates for desired effective date	☐
3.	Enclose a copy of the **Loss of Coverage letter** (if enrolling outside of Open Enrollment)	☐
4.	Pay your first premium and $5 monthly service fee: • Pay over the phone: (781) 228-2222. Payment Confirmation #:_____ -or- • Complete Electronic Payment Request Form -or- • Enclose check payable to HSA *(Receipt of payment does not guarantee coverage. HSA must receive completed enrollment materials by the carrier deadline)*	☐
5.	Send all required documents (including this checklist) to: **Corporate Office** 135 Wood Road Braintree, MA 02184 Sales Rep: Contact Info:	☐

Please Note: Complete applications and premium payment for new business must be received by HSA at least 5 business days prior to the requested effective date.

All coverage will be effective on the 1st day of the month. Once your enrollment has been approved and processed, you will receive a member confirmation by mail with your account number. Your permanent ID cards will be issued to you directly from the carrier. **Permanent ID cards generally take 7-10 business days from date your enrollment was approved and processed.**

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Individual Application
HEALTH NEW ENGLAND

Name	Requested Effective Date (Mo./Day/Yr.)
Home Address (street, city, state, zip)	Telephone ( )
Email Address	Fax ( )
Billing Address (street, city, state, zip) *If different than the home address*	Cell phone ( )

Are you a resident of the Commonwealth of Massachusetts? ☐ Yes ☐ No

You must be a Massachusetts resident to enroll in this health plan. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include but are not limited to being liable for the full amount of health care benefits or payments made, termination of coverage or fines.

Please write your Plan Selection here:

Certification *I certify that the information on this form is true and complete.*

Disclosures:

1. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
2. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
3. Payments not received by the 10th of the month are subject to a late fee, currently $25.
4. Payments not received by the 20th of the month are subject to a pending termination fee, currently $50.
5. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier. Reinstatements are subject to a reinstatement fee, currently $50.
6. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $20.
7. HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.
8. HSA insurance charges a monthly service fee per account.

Signature _____ **Print Name** _____ **Date** ___/___/___

Broker name (if applicable)

Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org
Phone: (413) 787-4000 | (800) 842-4464 | Enrollment Fax (413) 233-2635

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? ☐ YES ☐ NO
SS# (REQUIRED)	DOB MONTH DAY YEAR	GENDER ☐ MALE ☐ FEMALE
ADDRESS STREET	APT NO.	P.O. BOX
CITY STATE	ZIP	
TELEPHONE (HOME) ( )	TELEPHONE (WORK) ( )	EMAIL
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER	PRIMARY LANGUAGE SPOKEN	
ETHNICITY (use codes from back of form) 1ST	2ND	OTHER / RACE (Use codes from back of form)

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

DEPENDENT NAME(S) FIRST LAST (IF NOT SAME AS EMPLOYEE)	ETHNICITY (SEE REVERSE)	RACE (SEE REVERSE)	LANGUAGE (SEE REVERSE)	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
☐ SPOUSE ☐ OTHER				- -		- -			
				- -		- -			
				- -		- -			
				- -		- -			

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)

☐ **TERM POLICY** ☐ **TERM DEPENDENT** **END DATE** _____

☐ **NEW ENROLLMENT** ☐ **ADD DEPENDENT** ☐ **CHANGE MEMBER INFO**

CHOOSE REASON:

☐ **NEW HIRE** (DATE OF HIRE REQUIRED) ☐ **LOSS OF INSURANCE** ☐ **ANNUAL OE** **OTHER** _____ (SPECIFY)

CHOOSE REASON:

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

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

☐ **TRANSFER TO COBRA**

CHOOSE ONE: ☐ **HNE COBRA** ☐ **HNE COBRA WITH HEALTH EQUITY HRA**

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

DATE OF HIRE: _____ **HNE 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 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
R1	American Indian/Alaska Native
R2	Asian
R3	Black/African American
R4	Native Hawaiian or other Pacific Islander
R5	White
R9	Other Race
UNKNOWN	Unknown/not specified

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

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Electronic Payment Request Form

New Client? Pressed for time? Call (781) 228-2222 (8:30am-5:00pm, M-F) to quickly set up electronic payments. Just have your bank account and routing numbers ready. Or, complete this form:

Client Information:

Client Name: _____ Client Email: _____

New Client: Quote number and/or Application ID: _____

Current Client: 6 Digit HSA Account number: _____

Select payment type:

- ☐ **Recommended for new clients:** Withdraw both first month payment and recurring monthly payments
- ☐ First month payment only

If requesting recurring monthly payments, select date for withdrawal.

☐ 15th of the month ☐ 24th of the month

All outstanding balances owed, including fees, will be transferred at that time.

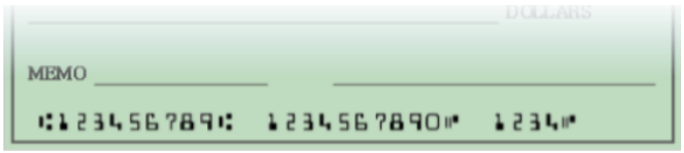
Bank Information:

Bank Name: _____ City: _____ State ____ Zip: _____

Name on Account: _____

Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings



Authorization:

I (we) hereby authorize HSA Insurance to initiate debit entries for my (our) checking account and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until HSA Insurance has received written notification from me (us) of its termination in such time and in such manner as to afford HSA and DEPOSITORY a reasonable opportunity to act on it. Note: all written debit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

Authorized Signer _____ _____

Sign Name Print Name and Title

Date: _____ Client Telephone: _____

Return Form

Please fax or secure email the completed form to: (781) 848-7020 or enrollment@hsainsurance.com
For changes to existing bank information, please contact Customer Service: (781) 228-2222.