WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

New Members—Register at mytuftshealthplan.com for fast access to your secure online account and personal benefit information.

Please fill in the "subscriber" sections of this membership application completely. Failure to do so could delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon. Keep a copy of this completed form as verification of employer coverage until you receive your permanent member ID card.

Subscriber Section

- Personal Information: Complete all enrollment information. For all plans, please select a primary care provider (PCP), be sure to fill out this section for all members, including dependents.
- Primary Care Provider: It is important that you choose a PCP right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are an established patient of the PCP you have listed. You are an established patient if you have routinely received health care services from this provider in the past. If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam. You will then need to transfer your medical records to your new PCP.
- Dependent Children: Dependent children are covered until their 26th birthday. Please be sure to fill out all appropriate information for each dependent, including primary care provider (if applicable).
- Other Health Coverage: If you have other insurance (including Medicare), please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the No box.

Intermediary Section

This section must be filled out by your Intermediary.

When the Application Is Complete

Please return this form to your Intermediary.

- Employee keeps a copy of form as temporary ID
- Tufts Health Plan and/or your Intermediary receives the original

If You Need Emergency Care

In an emergency, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP, if your plan requires one.

Please Note

By enrolling, you agree to and understand that if you or any of your enrolled dependents obtain a health care benefit or payment that you know you are not entitled to receive or be paid, or knowingly present or cause to be presented with fraudulent intent a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation.

Tufts Health Plan arranges for the provision of health care services but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Need Help?

If you need assistance selecting a PCP, visit mytuftshealthplan.com and use the doctor search feature.
If you need help filling out this form, call a member services specialist at 800.462.0224.

MEMBER ENROLLMENT FORM

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. **PLEASE RETURN THIS COMPLETED FORM TO YOUR INTERMEDIARY.**

FAILURE TO COMPLETE FORM WILL CAUSE A DELAY IN ENROLLMENT.

INTERMEDIARY USE ONLY

Name of Intermediary_____

Intermediary Group Number_____

TUFTS Health Plan

EMPLOYER SECTION

Group/Company Name_____ Group Number_____

Office Location_____ Date of Hire_____ Effective Date of Coverage_____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify)_____ Qualifying Event Date_____

SUBSCRIBER SECTION

Last Name_____ First Name_____ Middle Initial_____ Primary Language_____

Employee Social Security Number (required)_____ Date of Birth (MM/DD/YYYY)_____ / _____ / _____ Gender: ❑ Male ❑ Female

Residential Address (required)_____ City_____ State_____ ZIP_____

P.O. Box (optional) _____ City _____ State_____ ZIP_____

Email Address_____ Home Telephone (_____) _____ Work Telephone (_____) _____ Cell Phone (_____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Subscriber & Spouse ❑ Subscriber & Child ❑ Subscriber & Children ❑ Family ❑ Other_____

Primary Care Provider First Name_____ Last Name_____ PCP/NPI # _____ Are you an established patient of this PCP? ❑ Yes ❑ No

Members Enrolling First Name / Last Name (if different)	Gender M/F	Date of Birth (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (PCP First Name/Last Name)	Check if existing patient	PCP/NPI #
❑ Spouse ❑ Domestic Partner						
Child/Dependent						
Child/Dependent						
Child/Dependent						
Child/Dependent						
Child/Dependent						

Please check if you are using additional membership applications for additional dependent children. ❑

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan_____ Name of Plan Holder_____ Health Plan Number_____ Effective Date_____

Names of Family Members Covered_____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer _____

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 providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature_____ Date_____ Benefits Dept. Signature (required)_____ Telephone_____ Date_____

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides full and equal access to covered services under the federal *Americans with Disabilities Act of 1990* and Section 504 of the federal *Rehabilitation Act of 1973*. This includes free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - — Qualified interpreters
  - — Information written in other languages

If you need any of the above services, have questions regarding any provider directory information, or would like to report an inaccuracy or network access issue, please contact Tufts Health Plan Member Services at 800.462.0224.
To report provider directory inaccuracies electronically, please visit **https://tuftshealthplan.com/find-a-doctor** and select your plan. Search or select the Provider whose information you believe needs updating and click *"Tell us if something needs to change".*

Please note that if you have complaints regarding provider directory inaccuracies or provider network access issues, you also have the right at any time to contact the Commonwealth of Massachusetts Division of Insurance at (877) 563-4467, Option 2 or **www.mass.gov/doi**.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
1 Wellness Way, Canton, MA 02021-1166
Phone: 888.880.8699 ext. 48000,
[TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services:
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

tuftshealthplan.com | 800.462.0224

THP-OCR-Notice-11/2021

For no cost translation in English, call the number on your ID card.

Arabic . للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang kreyòl ayisyen, rele nimewo ki sou kat ID ou a.

Italian Per richiedere la traduzione in italiano senza costi aggiuntivi, chiamare il numero indicato sulla carta di identità.

Japanese 日本語の無料翻訳については**ID**カードに書いてある番号に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែជាភាសាឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통번역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo bąąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é bee nééł ho'dílzingo nantinígíí bikáá'.

Persian. بزنید زنگ تان شناسائی کارت در مندرج تلفن شماره بهـ فارسی رایگانن ترجمهـ برای

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para o português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Para servicios de traducción gratuitos en español, llame al número que aparece en su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

List-Languages-THP-ID-10/2020

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