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HMO PPO

ENROLLMENT/ADD/TERMINATION FORM

PLEASE PRINT AND COMPLETE ALL INFORMATION

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|
| EMPLOYEE NAME (FIRST, MIDDLE, LAST) | | GROUP/COMPANY NAME | | OPTION | | IF YOU'VE EVER BEEN AN HNE MEMBER, PLEASE LIST FORMER NAME (if applicable) AND FORMER IDENTIFICATION NUMBER _____ | | | | | | | | | | | |
| PCP FIRST & LAST NAME (does not apply to PPO) | | PCP PROVIDER ID# (Found in the provider directory) | | IS THIS YOUR DOCTOR NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | WILL YOU OR ANY MEMBER OF YOUR FAMILY BE COVERED THROUGH ANOTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| SS# | | DOB | | MONTH | | DAY | | YEAR | | GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | SUBSCRIBER'S NAME _____ DATE OF BIRTH _____ | | | | | |
| ADDRESS | | APT. NO. | | STREET | | PO BOX | | POLICY #NAME OF INSURANCE CO. _____ EFFECTIVE DATE _____ | | | | | | | | | |
| CITY | | STATE | | ZIP | | NAMES OF COVERED INDIVIDUALS _____ | | | | | | | | | | | |
| TELEPHONE (HOME) | | TELEPHONE (WORK) | | EMAIL | | IS EMPLOYEE RETIRED? <input type="checkbox"/> YES (provide copy of Medicare card) <input type="checkbox"/> NO | | | | | | | | | | | |
| MARITAL STATUS | | <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER | | PRIMARY LANGUAGE SPOKEN | | ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | |
| ETHNICITY (Use codes from back of form.) | | 1 st | | 2 nd | | Other | | RACE (Use codes from back of form) | | IF YES, <input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> BOTH A COPY OF YOUR MEDICARE CARD(S) MUST BE ATTACHED | | | | | | | |

EACH MEMBER MUST SELECT A PRIMARY CARE PHYSICIAN. IF A PCP IS NOT CHOSEN, HNE MAY NOT BE ABLE TO PROCESS YOUR CLAIMS (DOES NOT APPLY TO PPO).

| DEPENDENT NAME(S) | | ETHNICITY | RACE | DATE OF BIRTH | | | SEX | | SOCIAL SECURITY NUMBER | PCP LAST | FIRST | PROVIDER ID# | IS THIS YOUR DOCTOR NOW? | |
|--|--------|--------------------------------|-------------------------------|---------------|-----|----|-----|---|------------------------|----------|-------|--------------|--------------------------|---|
| FIRST | MIDDLE | LAST (if not same as employee) | (Use codes from back of form) | MO | DAY | YR | M | F | | | | | Y | N |
| <input type="checkbox"/> Spouse <input type="checkbox"/> Other | | | | - | - | | M | F | - | - | | | | |
| Dependent | | | | - | - | | M | F | - | - | | | | |
| Dependent | | | | - | - | | M | F | - | - | | | | |
| Dependent | | | | - | - | | M | F | - | - | | | | |

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, HNE 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 _____

(X) _____

BELOW SECTION TO BE COMPLETED BY EMPLOYER

| | | |
|---|--|---|
| <input type="checkbox"/> NEW ENROLLMENT EFF. DATE _____ REASON <input type="checkbox"/> NEW HIRE <input type="checkbox"/> PART-TIME TO FULL-TIME <input type="checkbox"/> ANNUAL OPEN ENROLLMENT <input type="checkbox"/> OTHER _____ <input type="checkbox"/> LOSS OF INSURANCE (must attach documents) <input type="checkbox"/> MOVED INTO SERVICE AREA | <input type="checkbox"/> CHANGE TO CURRENT POLICY EFF. DATE _____ REASON <input type="checkbox"/> CHANGE COVERAGE TYPE <input type="checkbox"/> NAME/ADDRESS CHANGE <input type="checkbox"/> ADD DEPENDENT LISTED ABOVE <input type="checkbox"/> LOSS OF INSURANCE (must attach documents) <input type="checkbox"/> TERMINATE DEPENDENT LISTED ABOVE <input type="checkbox"/> MARRIAGE <input type="checkbox"/> TRANSFER TO COBRA <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> TERMINATION OF POLICY END DATE _____ REASON <input type="checkbox"/> LEFT EMPLOYMENT <input type="checkbox"/> NO LONGER ELIGIBLE <input type="checkbox"/> VOLUNTARY CANCELLATION <input type="checkbox"/> DECEASED <input type="checkbox"/> MOVED FROM SERVICE AREA |
|---|--|---|

TYPE OF PLAN: HMO Advantage Plus (POS) PPO TYPE OF COVERAGE: INDIVIDUAL FAMILY EE+1

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 a 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 MA 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.

RACE Please choose from the following:

Fill in the code where indicated on the front of this form.

| Code | Description | R5 | White |
|------|---|---------|-----------------------|
| R1 | American Indian/Alaska Native | R9 | Other Race |
| R2 | Asian | UNKNOWN | Unknown/not specified |
| R3 | Black/African American | | |
| R4 | Native Hawaiian or other Pacific Islander | | |

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