

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 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. 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	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



One Monarch Place • Suite 1500 • Springfield, MA 01144-1500
 Phone 413.787.4000 • 800.842.4464 • Enrollment Fax 413.233.2635
 hne.com

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 CO. _____ POLICY # _____													
SS# (REQUIRED)		DOB MONTH DAY YEAR		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		NAMES OF COVERED INDIVIDUALS _____													
ADDRESS		STREET		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													
TELEPHONE (HOME)		TELEPHONE (WORK)		EMAIL		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				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>													
ETHNICITY (use codes from back of form)		RACE (Use codes from back of form)				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)		ETHNICITY		RACE		LANGUAGE		DATE OF BIRTH		GENDER		SOCIAL SECURITY # (REQUIRED)		PCP NAME (REQUIRED)		PROVIDER ID#		IS THIS YOUR DOCTOR NOW?	
FIRST LAST (IF NOT SAME AS EMPLOYEE)		(SEE REVERSE)						MO DAY YR				FIRST LAST						Y N	
<input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER								- -		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, 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

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:			
<input type="checkbox"/> NEW HIRE (DATE OF HIRE REQUIRED)		<input type="checkbox"/> LOSS OF INSURANCE		<input type="checkbox"/> ANNUAL OE	
<input type="checkbox"/> TRANSFER TO COBRA		OTHER _____ (SPECIFY)		<input type="checkbox"/> LEFT EMPLOYMENT <input type="checkbox"/> MOVED <input type="checkbox"/> VOLUNTARY CANCEL	
CHOOSE ONE: <input type="checkbox"/> HNE COBRA <input type="checkbox"/> HNE COBRA WITH HEALTH EQUITY HRA		<input type="checkbox"/> COBRA TERM		<input type="checkbox"/> NO LONGER ELIGIBLE <input type="checkbox"/> DECEASED	

TYPE OF PLAN: HMO PPO TYPE OF COVERAGE: INDIVIDUAL FAMILY

DATE OF HIRE: _____ HNE GROUP #: [] [] [] [] [] [] - [] [] [] [] EMPLOYER SIGNATURE _____ DATE _____