Health New England
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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
	SVRHT - East Longmeadow	

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 #:** S 0 3 0 4 2 — 0 0 1 9

Ⓧ _____

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	Colombian
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