Mass General Brigham
Health Plan

Enrollment and Change Form

399 Revolution Drive, Suite 940, Somerville, MA 02145
Tel 1-866-414-5533
Fax 617-526-1981

Application for Enrollment
- ☐ New employee
- ☐ Annual enrollment
- ☐ COBRA Continuation
- ☐ Involuntary loss of prior group coverage*
- ☐ Other _____

**Documentation required*

Change in Enrollment
- ☐ Add dependents
- ☐ Remove dependents
- ☐ PCP/Site change
- ☐ Termination
- ☐ Employee/dependent demographics
- ☐ Other _____

Reason for Change in Enrollment
- ☐ Marriage
- ☐ Birth of child
- ☐ Adoption of child*
- ☐ Divorce
- ☐ Left employment
- ☐ Reached age 65
- ☐ Add disabled dependents
- ☐ Moved out of service area
- ☐ Voluntary
- ☐ Loss of dependent eligibility
- ☐ Death, exact date _____

Please use a ball point pen and press down firmly.

Intermediary
- ☐ Group
- ☐ Non-group

Group Information

Mass General Brigham Health Plan group number		Employer name	
Date of employment Month Day Year		Effective Date Month Day Year	Plan design

Employee Information

Last name	First name	M.I.

Date of birth (mm/dd/yy)	Social Security Number	Sex (m/f/u)	Home phone – include area code	Email address
	- -			

Street mailing address	Apt.	P.O. Box	City	State	Zip code

PCP and Site Information

For help finding an in-network PCP, please go to MassGeneralBrighamHealthPlan.org and search our Find a Doctor tool. Then, select the product you are enrolling in from the drop down list. You may change your PCP at any time.

Primary care site	
Your Primary Care Physician (Last name, First, M.I.)	Existing patient? ☐Yes ☐No

Language

What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐English ☐Spanish ☐Sign Language ☐Arabic ☐Cantonese ☐Cape Verdean Creole ☐Chinese ☐French ☐Haitian Creole ☐Mandarin ☐Portuguese ☐Russian ☐Vietnamese ☐Other, please specify_____

What language do you write with most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐English ☐Spanish ☐Sign Language ☐Arabic ☐Cantonese ☐Cape Verdean Creole ☐Chinese ☐French ☐Haitian Creole ☐Mandarin ☐Portuguese ☐Russian ☐Vietnamese ☐Other, please specify_____

Confidential Personal Info

What is your race?

☐Black or African American ☐White ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Some Other Race (please specify) _____ ☐I choose not to answer ☐I am not sure / Don't know

How well do you speak English?

☐Very well ☐Well ☐Not well ☐Not at all ☐I choose not to answer ☐I am not sure / Don't know

What is your Hispanic Ethnicity?

☐Hispanic or Latino ☐Not Hispanic or Latino ☐I choose not to answer ☐I am not sure / Don't know

What is your ethnicity?

☐African ☐African American ☐American ☐Asian Indian ☐Brazilian ☐Cambodian ☐Cape Verdean ☐Caribbean Islander ☐Central American ☐Chinese ☐Colombian ☐Cuban ☐Dominican ☐Eastern European ☐European ☐Filipino ☐Guatemalan ☐Haitian ☐Honduran ☐Japanese ☐Korean ☐Laotian/Lao ☐Mexican ☐Middle Eastern or North African ☐Portuguese ☐Puerto Rican ☐Russian ☐Salvadoran ☐South American ☐Vietnamese ☐My ethnicity is not listed (please specify) _____ ☐I choose not to answer ☐I am not sure / Don't know

What is your gender identity?

☐Female ☐Male ☐Transgender ☐Genderqueer ☐Intersex ☐Unspecified ☐My gender identity is not listed (please specify) _____ ☐I choose not to answer ☐I am not sure / Don't know

What are your personal pronouns?

☐He/Him ☐She/Her ☐They/Them ☐Other (please specify) _____ ☐I choose not to disclose

What is your sexual orientation?

☐Bisexual ☐Lesbian or gay or homosexual ☐Queer, pansexual, and/or questioning ☐Straight or heterosexual ☐My sexual orientation is not listed (please specify) _____ ☐I choose not to answer ☐I am not sure / Don't know

Are you deaf or do you have difficulty hearing?

☐Yes ☐No ☐I choose not to answer ☐I am not sure / Don't know

Are you blind or do you have serious difficulty seeing, even when wearing glasses?

☐Yes ☐No ☐I choose not to answer ☐I am not sure / Don't know

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

☐Yes ☐No ☐I choose not to answer ☐I am not sure / Don't know

Do you have difficulty walking or climbing stairs?

☐Yes ☐No ☐I choose not to answer ☐I am not sure / Don't know

Do you have difficulty dressing or bathing? (5 years old and older)

☐Yes ☐No ☐I choose not to answer ☐I am not sure / Don't know

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old and older)

☐Yes ☐No ☐I choose not to answer ☐I am not sure / Don't know

Group Coverage

Type of Mass General Brigham Health Plan coverage (check only one)	In addition to Mass General Brigham Health Plan, my spouse or children are covered by a health plan offered by:			
☐ Self ☐ Individual & spouse ☐ Individual & child/children ☐ Family	Employer	Insurance co. name	Policy #	Effective date

Are you and/ or your spouse eligible for Medicare?						
	Self	☐ Yes ☐ No	If yes, are you enrolled in	☐ Medicare Part A	☐ Medicare Part B	Your Medicare policy number
	Spouse	☐ Yes ☐ No	If yes, is your spouse enrolled in	☐ Medicare Part A	☐ Medicare Part B	Your spouse's Medicare policy number

Please provide **ALL** information below for any eligible dependents you wish to enroll.

Spouse last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___-__-____	Sex (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___-__-____	Sex (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___-__-____	Sex (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___-__-____	Sex (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___-__-____	Sex (m/f/u)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Acknowledgement: The information supplied on this form is true and complete. I assign benefits to Mass General Brigham Health Plan for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan or other coverage. I (we) agree that Mass General Brigham Health Plan and its affiliated health care providers may obtain or release my (our) medical information including medical records, medical coverage available or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. I (we) understand that for Mass General Brigham Health Plan coverage to be in effect when medical care supplies are obtained, all care and supplies must be authorized and provided by participating care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Asigno (asignmos) beneficios a Mass General Brigham Health Plan por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que Mass General Brigham Health Plan y sus Proveedores de Cuidado de Salud afiliados puenden obtener o divulger mi (nuestra) información médica, incluyendo registros medicos, cobertura médica disponible o otra información médica, con el próposito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica y/o cuando es requerida por la ley. Yo entiendo (entendemos) que para que la cobertura de Mass General Brigham Health Plan tenga vigencia para la obtención de suministros médicos, toda la atención y todos los sumistros deben ser autorizados y proporcionados por un medico de cuidado primario paricipante autorizado (segun se indica arriba).

All information must be completed and form signed before processing can begin

Employee's signature: ____________________ Date: ________

Employer contact name (please print): ________________ Phone: __________ Employer's signature: ____________________ Date: ________