

Please use a ball point pen and press down firmly.

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 _____

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

Intermediary

- Group
- Non-group

Employee Information										
Last name					First name					M.I.
Date of birth (mm/dd/yy)	Social Security Number				Gender (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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Cantonese <input type="checkbox"/> Cape Verdean Creole <input type="checkbox"/> French <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Mandarin <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other, please specify _____	

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:
<input type="checkbox"/> Self <input type="checkbox"/> Individual & spouse <input type="checkbox"/> Individual & child/children <input type="checkbox"/> Family	Employer _____ Insurance co. name _____ Policy # _____ Effective date _____
Are you and/or your spouse eligible for Medicare?	Self <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you enrolled in <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B Your Medicare policy number _____ Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is your spouse enrolled in <input type="checkbox"/> Medicare Part A <input type="checkbox"/> 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	Gender (m/f/u)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Gender (m/f/u)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Gender (m/f/u)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Gender (m/f/u)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Gender (m/f/u)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (asignamos) 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 pueden obtener o divulgar mi (nuestra) información médica, incluyendo registros médicos, cobertura médica disponible o otra información médica, con el propósito 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 suministros deben ser autorizados y proporcionados por un medico de cuidado primario participante 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: _____

Return white original to Mass General Brigham Health Plan — Yellow copy to employer — Pink copy to employee