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 hnewhizkidz.com • hne.com

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	
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	-	-				

FOR DEPENDENT(S) AGED 21-26, I ATTEST TO THE FOLLOWING: (DEPENDENT ELIGIBILITY RULES MAY VARY FOR SELF-FUNDED PLANS.)

DEPENDENT NAME(S)	HE/SHE IS A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	I WILL CLAIM HIM/HER AS A DEPENDENT FOR IRS TAX PURPOSES IN THE CURRENT CALENDAR YEAR. <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, THE LAST YEAR I CLAIMED HIM/HER AS A DEPENDENT FOR IRS TAX PURPOSES WAS IN CALENDAR YEAR: _____
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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

<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
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TYPE OF PLAN: HMO Advantage Plus (POS) PPO **TYPE OF COVERAGE:** INDIVIDUAL FAMILY OTHER

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