TUFTS Health Plan

HSAinsurance

Employee Enrollment Form

Enrollee information

Enrollee name (first and last) _____ DOB ___/___/___ Sex ☐ M ☐ F

Enrollee address _____ Apt # _____ SSN _____ - _____ - _____

City _____ State _____ ZIP _____

Billing address _____ Apt # _____

City _____ State _____ ZIP _____

Email _____ Primary language _____

Phone number _____ Requested effective date ___/___/___

Primary care provider (PCP) name _____ PCP ID # _____ Existing patient ☐ Yes ☐ No

If the PCP you select is not in our network, we will select a PCP we think is right for you. You may change your PCP at any time.

*What is your race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Coverage type (select one)

☐ Self ☐ Individual/Spouse ☐ Individual/Child or children ☐ Family

Please select the plan in which you wish to enroll:

☐ _____

Have you recently gained access, or do you currently have access to an Individual Coverage Health Reimbursement Arrangement (ICHRA), or to a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)?

☐ **Unknown** ☐ **Not applicable** ☐ **ICHRA**

☐ **QSEHRA** (if checked, please respond to additional questions)

Which employer is providing the QSEHRA?

- ☐ Self
- ☐ Spouse
- ☐ Self and Spouse

How will this QSEHRA be used?

- ☐ Plan premiums only
- ☐ Plan premiums and medical/pharmacy claim reimbursement

Please provide **ALL** the information below for any eligible dependents you wish to enroll. You can use additional enrollment forms if you need more room:

Spouse name (first and last)_____ DOB _____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name _____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Dependent name (first and last)_____ DOB _____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

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☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Dependent name (first and last)_____ DOB _____/____/____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

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☐ Guamanian or Chamorro	☐ Japanese	☐ Korean	☐ Native Hawaiian	☐ Other Asian
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Dependent name (first and last)_____DOB_____/_____/_____ Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
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☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White	☐ Cuban
☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

Dependent name (first and last)_____DOB _____/____/____Sex ☐ M ☐ F

SSN ____-____-____ IRS dependent ☐ Yes ☐ No

PCP name_____ PCP ID # _____ Existing patient ☐ Yes ☐ No

*What is their race/ethnicity?

☐ American Indian or Alaskan Native	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ Filipino
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☐ Mexican, Mexican American or Chicano(a)	☐ Puerto Rican	☐ Hispanic or Latino	☐ Other_____	☐ Prefer not to answer

**Why is this question being asked? The Center for Medicare and Medicaid Services (CMS) has established goals for improving health care quality and reducing racial and ethnic disparities in health care. The goal is to remove any barriers to fair and unbiased treatment for all. By collecting information about your race and ethnic background, CMS may be able to identify possible issues that affect the care or treatment you receive. This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment and will remain confidential. A response to this question is optional.*

FORM CONTINUES
PLEASE COMPLETE ALL PARTS OF
ENROLLMENT FORM.

Disclosures

1. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
2. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
3. Payments not received by the 10th of the month are subject to a late fee, currently $50.
4. Payments not received by the 20th of the month are subject to a pending termination fee, currently $75.
5. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier. Reinstatements are subject to a reinstatement fee, currently $75.
6. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $50.
7. HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.
8. Once bound, the decision to rescind or retroactively terminate coverage is in the carrier's sole discretion.
9. HSA Insurance charges a monthly service fee per account.

The information supplied on this form is true and complete. I assign benefits to **Tufts 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 agree that **Tufts Health Plan** and its providers may obtain and/or release my/our medical information to administer benefits, evaluate medical care provided, conduct quality assurance reviews and analysis, conduct medical research, and/or as required by law. I understand that for **Tufts Health Plan** coverage to be in effect, all care, supplies, and services must be authorized, and/or provided by in-network providers.

You must be a Massachusetts resident to enroll in this health plan. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include but are not limited to being liable for the full amount of health care benefits or payments made, termination of coverage or fines.

ALL INFORMATION MUST BE COMPLETED AND SIGNED BEFORE PROCESSING CAN BEGIN.

Broker name_____ Broker Address_____