Individual Application Checklist

To ensure your application is processed as quickly and accurately as possible, follow these steps:

1. Complete and sign your Individual Enrollment Form. Make sure to select a primary care provider (PCP) for yourself and each dependent.	☐
2. Enclose a copy of your proposal/quote (if you received one), showing the premium (monthly payment) for your desired plan, and your requested effective date.	☐
3. Enclose a copy of the Loss of Coverage letter **(**if enrolling outside of Open Enrollment period)	☐
4. Pay your first premium and $15 monthly service fee: • Pay over the phone: (781) 228-2222. Payment Confirmation #:_____ -or- • Complete Electronic Payment Request Form -or- • Enclose check payable to HSA *(Receipt of payment does not guarantee coverage. HSA must receive completed enrollment materials by the carrier deadline)*	☐
5. Send your completed Individual Enrollment Form and all required documents, including this checklist, to: **HSA Main Office** **141 Longwater Drive, Suite 112** **Norwell, MA 02061** HSA must receive your complete application and your premium payment at least **five** business days prior to your requested effective date. Your coverage will be effective the first day of the following month.	☐

Once HSA approves and processes your application:

- Keep a copy of your application as your temporary ID.
- Watch the mail for your member confirmation with your account number.
- Look for your permanent ID card(s) from Tufts Health Direct, mailed within 7 – 10 days from the date HSA approves and processes your application.

Thank you for choosing Tufts Health Direct

TUFTS Health Plan

HSAinsurance

Individual 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

*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

*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

*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

*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

**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.

Date __/___/____

Broker name_____ Broker Address_____

HSAinsurance

Corporate Office
141 Longwater Drive, Suite 112
Norwell, MA 02061
(781) 228-2222

Electronic Payment Request Form

New Client? Pressed for time? Call (781) 228-2222 (8:30am-5:00pm, M-F) to quickly set up electronic payments. Just have your bank account and routing numbers ready. Or, complete this form:

Client Information:

Client Name: _____ Client Email: _____

New Client: Quote number and/or Application ID: _____

Current Client: 6 Digit HSA Account number: _____

Select payment type:

☐ **Recommended for new clients:** Withdraw both first month payment and recurring monthly payments
☐ First month payment only

If requesting recurring monthly payments, select date for withdrawal.

☐ 15th of the month ☐ 24th of the month

All outstanding balances owed, including fees, will be transferred at that time.

Bank Information:

Bank Name: _____ City: _____ State ____ Zip: _____

Name on Account: _____

Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings



Authorization:

I (we) hereby authorize HSA Insurance to initiate debit entries for my (our) checking account and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until HSA Insurance has received written notification from me (us) of its termination in such time and in such manner as to afford HSA and DEPOSITORY a reasonable opportunity to act on it. Note: all written debit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

Authorized Signer _____ _____

Sign Name | Print Name and Title

Date: _____ Client Telephone: _____

Return Form

Please fax or secure email the completed form to: (781) 848-7020 or enrollment@hsainsurance.com
For changes to existing bank information, please contact Customer Service: (781) 228-2222.