Member Transaction Form

Please print clearly and complete all applicable fields.

HHCS 2 ACA
A Direct Care HMO plan

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE **EMPLOYER:**		
Group number	Group name	Effective date: MM/DD/YYYY

Type of coverage: ❑ Individual ❑ Two-person ❑ Family ❑ Other _____

Please check off the reason you are filling out this form:

Adding coverage: ❑ New hire ❑ Annual open enrollment ❑ Other (Please explain in the Remarks section below.)

Ending coverage:

❑ Termination of employment ❑ Change to other insurance (Please provide the name of the other insurance in the Remarks section below.)

❑ Other (Please explain in the Remarks section below.)

Changes to existing coverage: (Please choose an option and explain in the Remarks section below.)

Change to: ❑ Individual plan ❑ Two-person plan ❑ Family plan ❑ COBRA ❑ Other

❑ Addition of a dependent (Please complete the Dependent Section of this form.) Date of qualifying event: _____

❑ Removal of a dependent

❑ Change in name, address or other application information

❑ Other

Remarks:

This form is not complete without an authorized employer signature on page 8.

THE FOLLOWING SECTIONS ARE TO BE FILLED OUT BY THE **EMPLOYEE (subscriber):**		
Please complete all applicable fields in this section.		
First name Middle initial (MI) Last name		Gender ❑ Male ❑ Female
Maiden name	Primary language	Birth date (MM/DD/YYYY)
Physical address		
City	State	ZIP code
Mailing address *(if different from physical above)*		
City	State	ZIP code
Would you be interested in receiving communications from Fallon Health via email? If so, please check the box and provide your email address: ❑		Date hired (MM/DD/YYYY)
Email address	Social Security #	
Home phone	Work phone	
Race (please choose one) ❑ White ❑ Black ❑ Hispanic ❑ Asian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Other		
Work status (please choose one) ❑ Full-time ❑ Part-time ❑ Retired ❑ COBRA		
Average # of hours worked weekly	Department #	Employee #
Does your spouse have health insurance from another source? ❑ Yes ❑ No		
Please provide the name of your selected Primary Care Provider (PCP). Is this your current PCP? ❑ Yes ❑ No		
First name Last name		

Benefits administrator: Please mail a copy of this form to: Fallon Health Enrollment Operations, 10 Chestnut St., Worcester, MA 01608.

DEPENDENT SECTION:

In this section, please list all dependents covered under this plan. If you need more room, please use an additional Member Transaction Form.

Dependent 1: First name	MI	Last name (include maiden name if applicable)		Gender ❑ Male ❑ Female
Relation to you			Social Security #	
Primary language		Race	Birth date (MM/DD/YYYY)	
Dependent 2: First name	MI	Last name (include maiden name if applicable)		Gender ❑ Male ❑ Female
Relation to you			Social Security #	
Primary language		Race	Birth date (MM/DD/YYYY)	
Dependent 3: First name	MI	Last name (include maiden name if applicable)		Gender ❑ Male ❑ Female
Relation to you			Social Security #	
Primary language		Race	Birth date (MM/DD/YYYY)	
Dependent 4: First name	MI	Last name (include maiden name if applicable)		Gender ❑ Male ❑ Female
Relation to you			Social Security #	
Primary language		Race	Birth date (MM/DD/YYYY)	
Dependent 5: First name	MI	Last name (include maiden name if applicable)		Gender ❑ Male ❑ Female
Relation to you			Social Security #	
Primary language		Race	Birth date (MM/DD/YYYY)	

I understand that my signature below means that I have read and I understand the contents of this form, and that I agree to the terms and conditions located on page 6 of this booklet.

X _____

Employee signature Date

Print name here _____

X _____

Employer signature Date

Print name here _____

Group name (please print) _____