

Member Transaction Form

Please print clearly and complete all applicable fields.

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE EMPLOYER:		
Group number	Group name	Effective date: MM/DD/YYYY
Type of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Two-person <input type="checkbox"/> Family <input type="checkbox"/> Other _____		
Please check off the reason you are filling out this form:		
Adding coverage: <input type="checkbox"/> New hire <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (Please explain in the Remarks section below.)		
Ending coverage: <input type="checkbox"/> Termination of employment <input type="checkbox"/> Change to other insurance (Please provide the name of the other insurance in the Remarks section below.) <input type="checkbox"/> 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: <input type="checkbox"/> Individual plan <input type="checkbox"/> Two-person plan <input type="checkbox"/> Family plan <input type="checkbox"/> COBRA <input type="checkbox"/> Other <input type="checkbox"/> Addition of a dependent (Please complete the Dependent Section of this form.) Date of qualifying event: _____ <input type="checkbox"/> Removal of a dependent <input type="checkbox"/> Change in name, address or other application information <input type="checkbox"/> 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):		
<i>Please complete all applicable fields in this section.</i>		
First name	Middle initial (MI)	Last name
		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/>		Date hired (MM/DD/YYYY)
Email address	Social Security #	
Home phone	Work phone	
Race (please choose one) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other		
Work status (please choose one) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA		
Average # of hours worked weekly	Department #	Employee #
Does your spouse have health insurance from another source? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please provide the name of your selected Primary Care Provider (PCP). Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		
First name	Last name	

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	<input type="checkbox"/> Male	<input type="checkbox"/> 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	<input type="checkbox"/> Male	<input type="checkbox"/> 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	<input type="checkbox"/> Male	<input type="checkbox"/> 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	<input type="checkbox"/> Male	<input type="checkbox"/> 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	<input type="checkbox"/> Male	<input type="checkbox"/> 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) _____