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: ❑ 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 10.

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

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 11 of this booklet.

X _____

Employee signature Date

Print name here _____

X _____

Employer signature Date

Print name here _____

Group name (please print) _____

Harrington Advantage is offered through Fallon Health & Life Assurance Company, Inc., a wholly owned subsidiary of Fallon Health.

Important information

Thank you for choosing us to provide your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information about your membership and your membership card(s). Also included in your New Member Kit will be information on how to obtain a *Member Handbook/Evidence of Coverage,* which defines your benefits and regulates benefit decisions. If you, or a dependent, need to seek medical services before you receive your Member ID card in the mail, all you have to do is give us a call. A member of our Customer Service team can help you. Simply ask for your Member ID card number. That is all you should need to receive services.

Harrington Advantage is a preferred provider organization (PPO) plan.

As such, we contract with a network of participating providers who have agreed to provide health care services to our members. Your use of participating providers is completely voluntary. Harrington Advantage in-network providers are tiered based on their accessibility to the community. Harrington HealthCare System providers can all be found in the lower-cost Tier 1 of the Harrington Advantage plan. You have access to a broader selection of providers—more than 40,000 throughout Massachusetts and southern New Hampshire—in Tier 3.

When you obtain covered services from Tier 1, Tier 2 and Tier 3 providers, you will receive the in-network level of benefits. We pay participating providers directly; you will not have to file claims when you use participating providers. When you obtain covered services from non-participating providers, you get the out-of-network level of benefits. You may need to submit a claim for covered services you receive from non-participating providers. For information on claims submission, refer to your Harrington Advantage *Member Handbook/Evidence of Coverage.*

Worldwide emergency medical care

Emergency services do not require referral or authorization. When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). For more information on emergency benefits and plan procedures for emergency services, consult your Harrington Advantage *Member Handbook/Evidence of Coverage.*

Questions?

Call the Harrington Advantage Customer Service team at 1-855-508-6226.

Consent

Submission of the Member Transaction Form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation, processing and payment of related claims.

Agreement

I am employed by the company named on this form, working at least 30 hours per week, full time, or 20 hours part time, and I receive an employer contribution to health insurance coverage (or I am otherwise eligible for the named company's health insurance coverage, e.g., as a former employee covered under COBRA). I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the Fallon Health/FHLAC coverage I have selected. I understand that Fallon Health is a Health Maintenance Organization (Fallon Preferred Care is a Preferred Provider Organization) and that membership becomes effective in accordance with the Fallon Health/FHLAC Group Agreement and the *Member Handbook/Evidence of Coverage*. I have read the Member Transaction Form. I understand how to obtain and use services under my Fallon Health/FHLAC coverage. I certify that all information is correct to the best of my knowledge. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the Fallon Health/FHLAC Group Agreement and your plan's *Member Handbook/ Evidence of Coverage*.