TUFTS Health Plan

Name of Tufts Health Plan subscriber:__________________________ **Tufts Health Plan Policy ID number:**__________________

SECTION 1 – EMPLOYMENT STATUS

Are you or your spouse actively working? (If YES, please complete the employment information.)

Tufts Health Plan policy holder: NO ____ YES ____ Employer______________________________ Phone # (_____)_____________

Spouse: NO ____ YES ____ Employer______________________________ Phone # (_____)_____________

Have you or your spouse retired? (If YES, please complete the retirement and former employer information.)

Tufts Health Plan policy holder : NO ____ YES ___ Retirement Date ___/___/___ Employer __________________________

Spouse: NO ____ YES ___ Retirement Date ___/___/___ Employer __________________________

Do you, your spouse, or children receive Social Security benefits as a result of a disability?

Tufts Health Plan policy holder: NO ____ YES ____ Date of Disability ___/___/___

Spouse: NO ____ YES ____ Date of Disability ___/___/___

Children: Name_____________ NO ____ YES ____ Date of Disability ___/___/___

Name_____________ NO____ YES ____ Date of Disability ___/___/___

SECTION 2 – MEDICARE

Are you, your spouse or children covered by Medicare?

Tufts Health Plan policy holder: NO ____ YES ____ (If YES, refer to your Medicare card to complete)
Spouse: NO ____ YES ____ (If YES, refer to your Medicare card to complete)
Children: NO ____ YES ____ (If YES, refer to your Medicare card to complete)

Name of Cardholder	Medicare ID#	Effective Dates	Medicare Entitlement Reason (check)
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure
		Part A: ___/___/___ Part B: ___/___/___	Age Disability Kidney Failure

SECTION 3—OTHER HEALTH INSURANCE

At this time or at any time in the last 12 months, are/were any members covered under your Tufts Health Plan policy, including yourself, your spouse or children, also covered by any other health insurance plan?

If YES, please refer to the *other* insurance card to complete this section. If NO, please proceed to Section 4.

Other Health Insurance company name ________________________________ Company Phone (____)______________________

Effective Date:___________________ Group # ______________________ Member ID # _____________________________

Name of person holding other insurance: _______________________________ Date of Birth of other policy holder: ____________

Does this other insurance cover you, your spouse or children?

Tufts Health Plan policy holder: NO ____ YES ____
Spouse: NO ___ YES ____
Children: NO ___ YES ____

SECTION 4—AUTHORIZATION

Name of person completing this form (please print):____

I certify that the above information is true and correct to the best of my knowledge:

Signature: ____ Phone #(____)__________________ Date: ____/____/____
E-mail address:_____________________________________

Please return this form to us at Tufts Health Plan COB, P.O. Box 9165, Watertown, MA 02471. Thank you!