WELCOME TO TUFTS HEALTH PLAN

Please complete all of the member sections of the membership application in full. Failure to do so could delay enrollment. You must be a Massachusetts resident to enroll in any of these plans.

Member Sections

Personal Information - Complete all enrollment information. If your plan requires the selection of a primary care physician (HMO) please be sure to fill out this section for all members, including dependents. Note: Your Social Security number is not required for enrollment.

If you have problems finding a primary care physician, you can visit our website, tuftshealthplan.com/enrollnow.

Dependent children - Dependent children may be covered until their 26th birthday. Please be sure to fill out all appropriate information for each dependent, including primary care physician (if applicable).

Other Health Coverage - If you have other insurance (including Medicare) please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the "no" box.

When the application is complete

PLEASE RETURN THIS FORM TO:
Tufts Health Plan
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

Member Please Note:

By enrolling, you certify that: (a) you meet the definition of an eligible individual under Massachusetts law; (b) you are not eligible for Medicare or Medicaid unless you are enrolling during a regular open enrollment period; and (c) you agree to and understand that if you or any of your enrolled dependents (1) obtain a health care benefit or payment that you know you are not entitled to receive or be paid; or (2) knowingly present or cause to be presented, with fraudulent intent, information on this application, or a claim that contains a false statement, you may be liable for the full amount of health care benefits or payments made and for reasonable attorney's fees and costs, including cost of investigation. In addition, we may terminate your coverage.

Tufts Health Plan arranges for the provision of health care services, but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent health care professionals and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Need Help?

If you need assistance filling out this form, our member specialists are here to help. Call 800.957.6596. You can also log onto our website at tuftshealthplan.com/enrollnow for more information.

Select Network Disclosure Notice Provider Network Access

Limited Provider Network

Select Network plans provide access to providers that are not the same as the Tufts Health Plan's standard provider network.

Your member identification card will say Select Network on it. The designation Limited will be on the top right-hand side of the card that applies to the health benefit plan you have chosen.

I understand that: I may not change plans during a policy year because of changes to the provider network; and the plan provides access to providers that may not be the same as Tufts Health Plan's standard provider network. In addition, I have reviewed the Select Network provider directory or online search tool and understand that this plan only provides access to covered benefits from the providers in the Select Network directory. I understand that it is my responsibility to ensure that a provider I voluntarily choose is enrolled in the Select provider network before obtaining care. In choosing the Select plan, I understand I will be required to choose a different provider for treatment if a provider I now see is not enrolled in the Select provider network. Finally, I certify that I have received the guide before beginning and completing the application/enrollment process.

My signature on the application certifies that I have read and understand the above and that I have received the guide.

We collect email addresses and cell phone numbers ("your information") as part of the registration process. We may use your information to notify you of online activity related to the security and privacy of your accounts, such as, retrievals of username, etc. In addition we may use your information to send you health and wellness information and other updates that might be of interest to you as members of Tufts Health Plan. On certain occasions we may also share your information with providers in our network so that they may send you information that describes health-related products and/or services offered by the provider and included in your plan of benefits, enhancements to your plan, and/or benefits and services available to you as a health plan member that add value to, but are not part of, your plan of benefits. Each time we or any such provider sends health and wellness information and other updates, you will be given the opportunity to opt-out of receiving similar emails or cell phone communications in the future. Please note that you cannot opt-out of receiving emails that notify you of online activity since these are necessary to protect the privacy and security of Web accounts.

CS581035248-2021-COM-30100028-202010

MEMBER ENROLLMENT FORM

Please print or type. Please be sure application is completed in full to ensure enrollment.

FAILURE TO COMPLETE THE UNDERLINED SECTIONS
MAY CAUSE A DELAY IN ENROLLMENT.

CHOOSE PLAN TYPE

- ❑ Advantage HMO 1000
- ❑ Advantage HMO 2000
- ❑ Advantage HMO 2000 (80%)
- ❑ Advantage HMO 4000
- ❑ Select Advantage HMO 1500
- ❑ Select Advantage HMO 2500
- ❑ Advantage HMO Saver 2500
- ❑ Advantage HMO Saver 3600

Other Plan Type: ____________________

Member Section ❑ New Enrollee or ❑ Qualifying Event for Changes to Plan (MUST specify) ______________________ Qualifying Event Date__________ Requested Effective Date of Coverage_________

1. E-mail

2. Have you or anyone in your family used tobacco products, e.g., cigarettes, chewing tobacco, etc., in the last 12 months? ❑ Yes ❑ No

3. Last Name | 4. First Name | 5. Middle Initial | 6. Social Security Number (SSN) (optional)

7. Mailing Address (Home Address) | 8. Apt# | 9. City | 10. State | 11. ZIP | 12. Gender ❑ M ❑ F | 13. Date of Birth / / (month day year)

14. Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner

15. Type of Coverage Requested ❑ Individual ❑ Subscriber/Spouse ❑ Subscriber/Child or Children ❑ Family

16. Primary Care Physician | 17. PCP ID# | 18. Check if currently used for primary care ❑

19. Home Telephone ( ) | 20. Work Telephone ( ) | 21. Fitness Center | 22. Primary Language

Members Enrolling (Last name, if different)	Sex M/F	Date of Birth	Social Security Number (optional)	Fitness Center	Choose a Primary Care Physician for each member	Tufts Health Plan Affiliated Hospital	Check if currently used for primary care	PCP ID#
23. Spouse/DP			- -					
24. Child/Dependent			- -					
25. Child/Dependent			- -					
26. Child/Dependent			- -					
27. Child/Dependent			- -					
28. Child/Dependent			- -					

29. Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan | Name of Plan Holder | Health Plan Number | Effective Date | Names of Family Members Covered

30. Is spouse employed? ❑ Yes ❑ No If yes, Name and Address of Employer

31. Please check If you are using additional membership applications for additional dependent children ❑

The information supplied on this form is true and complete. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payment directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (or we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the member services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

If you are enrolling in a Select Limited Provider Network Plan:
I am enrolling in a Select Limited Provider Network Plan and certify that I have read and understand the disclosure notice on the front of this application.

Signature (required): ________________________________ Date: ______________

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides full and equal access to covered services under the federal *Americans with Disabilities Act of 1990* and Section 504 of the federal *Rehabilitation Act of 1973*. This includes free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of the above services, have questions regarding any provider directory information, or would like to report an inaccuracy or network access issue, please contact Tufts Health Plan Member Services at 800.462.0224. To report provider directory inaccuracies electronically, please visit **https://tuftshealthplan.com/find-a-doctor** and select your plan. Search or select the Provider whose information you believe needs updating and click *"Tell us if something needs to change"*.

Please note that if you have complaints regarding provider directory inaccuracies or provider network access issues, you also have the right at any time to contact the Commonwealth of Massachusetts Division of Insurance at (877) 563-4467, Option 2 or **www.mass.gov/doi**.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000,
[TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services:
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

tuftshealthplan.com | 800.462.0224

For no cost translation in English, call the number on your ID card.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك .

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang kreyòl ayisyen, rele nimewo ki sou kat ID ou a.

Italian Per richiedere la traduzione in italiano senza costi aggiuntivi, chiamare il numero indicato sulla carta di identità.

Japanese 日本語の無料翻訳については**ID**カードに書いてある番号に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통번역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສຳລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo bááh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian. بزنید زنگ تان شناسائی کارت در مندرج تلفن شماره به فارسی رایگانن ترجمه برای

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para o português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Para servicios de traducción gratuitos en español, llame al número que aparece en su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

List-Languages-THP-ID-10/2020

705 Mount Auburn Street
Watertown, MA 02472-1508
tuftshealthplan.com