



Select the plan available to you  
that you would like to join:

HMO  
EPO  
PPO Plus

Please select all that apply.

Application for enrollment

New employee  
Annual enrollment  
COBRA continuation  
Involuntary loss of prior group coverage\*  
  
Other \_\_\_\_\_  
*\*Documentation required*

Change in enrollment

Add dependents  
Remove dependents  
PCP/site change  
Termination  
Employee/dependent demographics  
  
Other \_\_\_\_\_

Reason for change in enrollment

Marriage  
Birth of child  
Adoption of child\*  
Divorce  
Left employment  
Reached age 65  
  
Add disabled dependents  
Moved out of service area  
Voluntary  
Loss of dependent eligibility  
Death, exact date \_\_\_\_\_

Group information if applicable. For the employer to fill out.

Mass General Brigham Health Plan group number				Employer name				
Date of employment	Month	Day	Year	Effective Date	Month	Day	Year	Plan name

For intermediaries only

Group  
Non-group  
ICHRA  
QSEHRA

Employee information

Last name				First name			M.I.	Email address
Date of birth	Social Security Number		Home phone – include area code		Sex M F U		Yes, I would like Mass General Brigham Health Plan to send me email messages related to my plan benefits and services.	
Street mailing address							Mobile phone	
Apt.	P.O. Box	City		State		Zip code		Yes, I would like Mass General Brigham Health Plan to send me text messages related to my plan benefits and services.

PCP and site information

This section is for HMO members or EPO members in **Massachusetts and New Hampshire only**

For help finding an in-network PCP, please go to **MGBHP.org** and search our Find a Doctor tool. Then, select the product you are enrolling in from the drop down list. You may change your PCP at any time.

Primary care site	Your primary care provider (Last name, First, M.I.)	Existing patient? Yes No
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Confidential personal information

This section is optional

What is your race? Black or African American    White    American Indian or Alaska Native    Asian    Native Hawaiian or other Pacific Islander    Other (please specify) _____ I choose not to answer    I am not sure/Don't know											
How well do you speak English? Very well    Well    Not well    Not at all    I choose not to answer    I am not sure/Don't know											
What is your Hispanic Ethnicity? Hispanic or Latino    Not Hispanic or Latino    I choose not to answer    I am not sure/Don't know											
What is your ethnicity? African    African American    American    Asian Indian    Brazilian    Cambodian    Cape Verdean    Caribbean Islander    Central American    Chinese Colombian    Cuban    Dominican    Eastern European    European    Filipino    Guatemalan    Haitian    Honduran    Japanese    Korean Laotian/Lao    Mexican    Middle Eastern or North African    Portuguese    Puerto Rican    Russian    Salvadoran    South American    Vietnamese My ethnicity is not listed (please specify)    I choose not to answer    I am not sure/Don't know											
What is your gender identity? Female    Male    Transgender    Genderqueer    Intersex    Unspecified    My gender identity is not listed (please specify) _____ I choose not to answer    I am not sure/Don't know											
What are your personal pronouns? He/Him    She/Her    They/Them    Other (please specify)    I choose not to disclose											
What is your sexual orientation? Bisexual    Lesbian or gay or homosexual    Queer, pansexual, and/or questioning    Straight or heterosexual    My sexual orientation is not listed (please specify) _____ I choose not to answer    I am not sure/Don't know											
Are you deaf or do you have difficulty hearing? Yes    No    I choose not to answer    I am not sure/Don't know											
Are you blind or do you have serious difficulty seeing, even when wearing glasses? Yes    No    I choose not to answer    I am not sure/Don't know											
Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older) Yes    No    I choose not to answer    I am not sure/Don't know											
Do you have difficulty walking or climbing stairs? Yes    No    I choose not to answer    I am not sure/Don't know											
Do you have difficulty dressing or bathing? (5 years old and older) Yes    No    I choose not to answer    I am not sure/Don't know											
Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old and older) Yes    No    I choose not to answer    I am not sure/Don't know											

Group coverage

Type of Mass General Brigham Health Plan coverage (check only one)				In addition to Mass General Brigham Health Plan, my spouse or children are covered by a health plan offered by:			
Self	Individual & spouse	Individual & child/children	Family	Employer	Insurance co. name	Policy #	Effective date
Are you and/or your spouse eligible for Medicare?	Self	Yes	No	If yes, are you enrolled in	Medicare Part A	Medicare Part B	Your Medicare policy number
	Spouse	Yes	No	If yes, is your spouse enrolled in	Medicare Part A	Medicare Part B	Your spouse's Medicare policy number

Please provide **ALL** information below for any eligible dependents you wish to enroll.

This column below is for HMO members or EPO members in Massachusetts and New Hampshire.

Spouse last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Sex M F U	Other insurance? Yes No		Primary care physician (last name, first name, M.I.)	Yes No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Sex M F U	Other insurance? Yes No		Primary care physician (last name, first name, M.I.)	Yes No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Sex M F U	Other insurance? Yes No		Primary care physician (last name, first name, M.I.)	Yes No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Sex M F U	Other insurance? Yes No		Primary care physician (last name, first name, M.I.)	Yes No
Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Sex M F U	Other insurance? Yes No		Primary care physician (last name, first name, M.I.)	Yes No

Acknowledgement: The information provided on this form is true and complete. I assign benefits to Mass General Brigham Health Plan for the cost of services when the liability for payment is the responsibility of another plan, worker's compensation plan, or other coverage. I (we) agree that Mass General Brigham Health Plan and its affiliated health care providers may obtain or release my (our) medical information including medical records, medical coverage available, or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. If enrolling in the HMO or EPO, I (we) understand that for Mass General Brigham Health Plan coverage to be in effect when medical care supplies are obtained, all care and supplies must be authorized and provided by participating care physicians (as listed above).

All information must be completed and form signed before processing can begin		Employee's signature: _____	Date: _____
Employer contact name (please print): _____	Phone: _____	Employer's signature: _____	Date: _____