

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 _____

Change in enrollment

Add dependents

Remove dependents

PCP/site change

Termination

Employee/dependent demographics

Other _____

Reason for change in enrollment

Marriage

Add disabled dependents

Birth of child

Moved out of service area

Adoption of child*

Voluntary

Divorce

Loss of dependent eligibility

Left employment

Death, exact date _____

Reached age 65

*Documentation required

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

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		
Street mailing address								
Apt.	P.O. Box	City		State		Zip code	Mobile phone	
Yes, I would like Mass General Brigham Health Plan to send me email messages related to my plan benefits and services.								
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

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
Colombian	Cuban	Dominican	Eastern European	European	Filipino	Guatemalan	Haitian	Honduran
Laotian/Lao	Mexican	Middle Eastern or North African	Portuguese	Puerto Rican	Russian	Salvadoran	Japanese	Korean
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: _____