

Please use a ball point pen
and press down firmly.

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

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

Employee Information

Last name												First name												M.I.	
Date of birth (mm/dd/yy)				Social Security Number								Gender (m/f/u)		Home phone – include area code						Email address					
Street mailing address										Apt.		P.O. Box		City						State				Zip code	

PCP and Site Information

Members in Massachusetts and New Hampshire must designate a Primary Care Provider (PCP). For help finding an in-network PCP, please go to **MassGeneralBrighamHealthPlan.org** and search our Find a Doctor tool. Then, select the Complete Access EPO network from the drop down list. You may change your PCP at any time.

Primary care site																	
Your Primary Care Physician (Last name, First, M.I.)																Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Language

What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐ English ☐ Spanish ☐ Sign Language ☐ Arabic ☐ Cantonese ☐ Cape Verdean Creole ☐ Chinese ☐ French ☐ Haitian Creole ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Vietnamese
☐ Other, please specify _____

What language do you write with most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐ English ☐ Spanish ☐ Sign Language ☐ Arabic ☐ Cantonese ☐ Cape Verdean Creole ☐ Chinese ☐ French ☐ Haitian Creole ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Vietnamese
☐ Other, please specify _____

Confidential Personal Info

What is your race?

☐ Black or African American ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race (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) <input type="checkbox"/> Self <input type="checkbox"/> Individual & spouse <input type="checkbox"/> Individual & child/children <input type="checkbox"/> Family		In addition to Mass General Brigham Health Plan, my spouse or children are covered by a health plan offered by: Employer		Insurance co. name	Policy #	Effective date
Are you and/or your spouse eligible for Medicare?	Self <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are you enrolled in <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B		Your Medicare policy number		
	Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is your spouse enrolled in <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B		Your spouse's Medicare policy number		

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

Spouse last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	Social Security Number	Sex (m/f/u)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Acknowledgement: The information supplied 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. 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).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Asigno (asignmos) beneficios a Mass General Brigham Health Plan por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que Mass General Brigham Health Plan y sus Proveedores de Cuidado de Salud afiliados pueden obtener o divulgar mi (nuestra) información médica, incluyendo registros medicos, cobertura médica disponible o otra información médica, con el propósito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica y/o cuando es requerida por la ley. Yo entiendo (entendemos) que para que la cobertura de Mass General Brigham Health Plan tenga vigencia para la obtención de suministros médicos, toda la atención y todos los suministros deben ser autorizados y proporcionados por un medico de cuidado primario participante autorizado (segun se indica arriba).

All information must be completed and form signed before processing can begin

Employer contact name (please print): _____ Phone: _____ Employee's signature: _____ Date: _____ Employer's signature: _____ Date: _____