Mass General Brigham Health Plan

Enrollment and change form

399 Revolution Drive, Suite 940, Somerville, MA 02145

Tel 866-414-5533
Fax 617-526-1981

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

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: __________