Member Transaction Form

Fallon Health
Fallon Health & Life Assurance Co., Inc.

Fallon Direct Benchmark HMO

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE EMPLOYER:

Group number	Group name	Effective date: (MM/DD/YYYY)
55500-80	Town of Concord	

Please check off the reason you are filling out this form:

Adding coverage: ❑ New hire ❑ Annual open enrollment ❑ Other (Please explain in the Remarks section below.)

Ending coverage:

❑ Termination of employment ❑ Change to other insurance (Please provide the name of the other insurance in the Remarks section below.)

❑ Other (Please explain in the Remarks section below.)

Changes to existing coverage: (Please choose an option and explain in the Remarks section below.)

Change to: ❑ Individual plan ❑ Family plan ❑ COBRA ❑ Other

❑ Addition of a dependent (Please complete the dependent section of this form.) Date of qualifying event:† ____________

❑ Removal of a dependent ❑ Proof of qualifying event documentation included

❑ Change in name, address or other application information ❑ Other

Remarks:

This form is not complete without an authorized employer signature on page 2.

THE FOLLOWING SECTIONS ARE TO BE FILLED OUT BY THE EMPLOYEE (subscriber):

Please complete all applicable fields in this section.

Provider network: ❑ Direct Care* ❑ Select Care ❑ Fallon Preferred Care ❑ Steward Community Care*

Plan name: ____________

First name	Middle initial (MI)	Last name	Gender ❑ Male ❑ Female

Maiden name	Primary language	Birth date (MM/DD/YYYY)

Street address

City	State	ZIP code

Mailing address *(if different from street above)*

City	State	ZIP code

Would you be interested in receiving communications from Fallon via email? If so, please check the box and provide your email address: ❑	Home phone Mobile phone

Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date hired (MM/DD/YYYY)	Work phone

Race (please choose one) ❑ White ❑ Black ❑ Hispanic ❑ Asian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Other

Work status (please choose one) ❑ Full time ❑ Part time ❑ Retired ❑ COBRA

Average # of hours worked weekly	Department #	Employee #

Does your spouse have health insurance from another source? ❑ Yes ❑ No

Please provide the name of your selected primary care provider (PCP). Is this your current PCP? ❑ Yes ❑ No

First name MI Last name

†Documentation required for qualifying event.

Benefits administrator: Please mail the white and yellow copies of this form to: Fallon Health Enrollment Operations, 10 Chestnut St., Worcester, MA 01608. The pink copy is for the employee. Or email form to: enrollmentrequests@fallonhealth.org. Or fax form to: 1-508-831-1136.

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DEPENDENT SECTION:

In this section, please list all dependents covered under this plan. If you need more room, please use an additional Member Transaction Form.

Dependent 1: First name	MI	Last name (include maiden name if applicable)	Gender ❑ Male ❑ Female
Relation to you		Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Primary language	Race	Birth date (MM/DD/YYYY)	
Street address (if different from subscriber's)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No			
First name	MI	Last name	

Dependent 2: First name	MI	Last name (include maiden name if applicable)	Gender ❑ Male ❑ Female
Relation to you		Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Primary language	Race	Birth date (MM/DD/YYYY)	
Street address (if different from subscriber's)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No			
First name	MI	Last name	

Dependent 3: First name	MI	Last name (include maiden name if applicable)	Gender ❑ Male ❑ Female
Relation to you		Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Primary language	Race	Birth date (MM/DD/YYYY)	
Street address (if different from subscriber's)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No			
First name	MI	Last name	

Dependent 4: First name	MI	Last name (include maiden name if applicable)	Gender ❑ Male ❑ Female
Relation to you		Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Primary language	Race	Birth date (MM/DD/YYYY)	
Street address (if different from subscriber's)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No			
First name	MI	Last name	

Dependent 5: First name	MI	Last name (include maiden name if applicable)	Gender ❑ Male ❑ Female
Relation to you		Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Primary language	Race	Birth date (MM/DD/YYYY)	
Street address (if different from subscriber's)			
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No			
First name	MI	Last name	

I understand that my signature below means that I have read and I understand the contents of this form, and that I agree to the terms and conditions located on the back of this form.

X ____ ______________________

Employee signature *(REQUIRED)* Print name here Date

X ____ ______________________

Employer signature *(REQUIRED)* Print name here Date

Group name (please print) ____

* Direct Care and Steward Community Care provide access to networks that are smaller than the Select Care network. In these plans, members have access to network benefits only from the providers in their respective network. Please consult the respective provider directory—paper copies can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care and Steward Community Care.

**Required for tax purposes