Mass General Brigham Health Plan *in partnership with* Small Business Service Bureau, Inc.

38 Austin Street
Worcester, MA 01609
1-800-472-7199

2023 Member Enrollment Change Form

Health Insurance Plan (check one):

- ❑ Complete HMO 2000 30/60/350 with Care Complement
- ❑ Complete HMO 2500 15%/35%
- ❑ Complete HMO 2850
- ❑ Complete HMO HSA 3000 ER 350 Enhanced FlexRx
- ❑ Other_____

Coverage Type (check one):

- ❑ Self
- ❑ Self + Spouse
- ❑ Self + Dependent child/ren
- ❑ Family

Effective Date Enrollment/Change/Cancellation:

/ /

Enrollment Application (check one):

- ❑ New Enrollment
- ❑ Renewal
- ❑ Enrollment Change
- ❑ Enrollment Cancellation
- ❑ Loss of Insurance
- ❑ Add/Delete Dependent(s)
- ❑ Other (please describe) _____

Subscriber Information

IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN. AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.

FIRST MI LAST (IF NOT THE SAME AS EMPLOYEE)	DATE OF BIRTH MO DAY YR	SEX			RELATION CODE	SOCIAL SECURITY NUMBERS	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU AN EXISTING PATIENT?	
SUBSCRIBER	- -	M	F	UNSPECIFIED	O1	- -		Y	N
SPOUSE	- -	M	F	UNSPECIFIED		- -		Y	N
DEPENDENT	- -	M	F	UNSPECIFIED		- -		Y	N
DEPENDENT	- -	M	F	UNSPECIFIED		- -		Y	N
DEPENDENT	- -	M	F	UNSPECIFIED		- -		Y	N
DEPENDENT	- -	M	F	UNSPECIFIED		- -		Y	N

Acknowledgement: The information supplied on this form is true and complete. I assign benefits to AllWays Health Partners for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan or other coverage. I (we) agree that AllWays Health Partners 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 AllWays Health Partners 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 AllWays Health Partners por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que AllWays Health Partners y sus Proveedores de Cuidado de Salud afiliados puenden obtener o divulger mi (nuestra) información médica, incluyendo registros medicos, cobertura médica disponible o otra información médica, con el próposito de administrar beneficios, evaluar la attención 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 AllWays Health Partners tenga vigencia para la obtención de suministros médicos, toda la atención y todos los sumistros deben ser autorizados y proporcionados por un medico de cuidado primario paricipante autorizado (segun se indica arriba).

THE APPLICANT MUST SIGN AND DATE THIS FORM FOR ENROLLMENT. IF THE APPLICANT IS A CHILD UNDER AGE 19, THIS FORM MUST INSTEAD BE SIGNED BY A PARENT OR LEGAL GUARDIAN.

APPLICANT SIGNATURE	DATE	APPLICANT'S PARENT/LEGAL GUARDIAN (IF APPLICABLE)	DATE

HOME STREET ADDRESS

CITY STATE ZIP CODE

HOME OR CELL PHONE NUMBER

MAILING ADDRESS **(IF DIFFERENT)**

CITY STATE ZIP CODE

EMAIL ADDRESS

Steps to Complete Enrollment: You must complete these steps to ensure that your coverage will begin by the effective date you selected.

- ❑ **1** Complete this application (Choose a plan, select an effective date, and sign application.)
- ❑ **2** Submit proof of residency.
- ❑ **3** If applying outside of open enrollment please submit qualifying event information.
- ❑ **4** All materials listed above must be received at least **5 business days before** requested effective date.

Mail your completed materials to:
Small Business Service Bureau, Inc.
38 Austin Street
Worcester, MA 01609

Fax materials to:
Small Business Service Bureau, Inc.
508-792-3872

Or Email to:
info@sbsb.com

Remember to include a copy of your premium quote.

Questions? Please call us at: 1-800-472-7199

IMPORTANT: Our health plans are for Massachusetts residents only. Proof of residency is required before your coverage begins.