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

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

# 2024 Member Enrollment Change Form

**Health Insurance Plan (check one):**

- ❑ Complete HMO 2000 25/60 with Care Complement
- ❑ Complete HMO 2500 30/55/500 with Care Complement
- ❑ Complete HMO HSA 2500 30/45/450 Enhanced FlexRx
- ❑ Complete HMO 2850
- ❑ 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 NUMBER* | SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER | ARE YOU AN EXISTING PATIENT? | |
|---|---|---|---|---|---|---|---|---|---|
| SUBSCRIBER | - - | M | F | UNSPECIFIED | 01 | - - | | 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 |

*Social security number(s) on application (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. *(Social security numbers are not displayed on the member's ID card.)*

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 | MAILING ADDRESS (**IF DIFFERENT**) |
| CITY STATE ZIP CODE | CITY STATE ZIP CODE |
| HOME OR CELL PHONE NUMBER | 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** The first month's full premium payment
- ❑ **3** Proof of Massachusetts residency *(our Non-Group Health Plans are for Massachusetts residents only)*
- ❑ **4** Application outside of Open Enrollment requires proof of qualifying life event for enrollment *(Open Enrollment begins 11/1 for an effective date of 1/1 each year)*

**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.