The Employee Advantage
Employer Group Membership Transaction Form

The Employee Advantage
Provided by UMass Memorial Health Care

Fallon Health & LIfe Assurance Company, Inc., a wholly owned subsidiary of Fallon Community Health Plan.

Please complete all fields on form. (Please print clearly.)

EMPLOYEE INFORMATION — IF WE MAY CONTACT YOU BY E-MAIL, PLEASE SUPPLY ADDRESS WHERE INDICATED.*

NAME (LAST, FIRST, MI) | MAIDEN NAME (IF APPLICABLE) | PRIMARY LANGUAGE

STREET ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE ( )

BIRTH DATE | SEX ☐ M ☐ F | RACE ☐ WHITE ☐ BLACK ☐ HISPANIC ☐ ASIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ OTHER

WORK PHONE ( ) | *E-MAIL | SOCIAL SECURITY NO. | STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ COBRA

DATE HIRED | AVERAGE NO. HOURS WORKED | DEPARTMENT # | EMPLOYEE # | IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO | PRIMARY CARE PHYSICIAN SELECTION

EVER TREATED BY THIS PHYSICIAN? (IF YES, UNDER WHAT NAME?) ☐ NO ☐ YES ____________________

IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: MO / DAY / YR

DEPENDENT INFORMATION

PRIMARY CARE PHYSICIAN (PCP) SEE PROVIDER LIST

NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE) ☐ M ☐ F | SOCIAL SECURITY NO. | PCP SELECTION
RELATION ____________ | BIRTHDATE MO / DAY / YEAR | PRIMARY LANGUAGE | EVER TREATED BY THIS DOCTOR? ☐ YES ☐ NO
*E-MAIL | RACE

NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE) ☐ M ☐ F | SOCIAL SECURITY NO. | PCP SELECTION
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*E-MAIL | RACE

GROUP INFORMATION

GROUP NUMBER

GROUP NAME

REQUESTED EFFECTIVE DATE

TYPE OF COVERAGE
☐ INDIVIDUAL ☐ FAMILY
☐ OTHER ____________

REASON FOR TRANSACTION

ADDING COVERAGE
- ☐ New hire
- ☐ Annual open enrollment
- ☐ Other (explain in “Remarks” section below)

ENDING COVERAGE
- ☐ Termination of employment
- ☐ Change to other insurance (give name of other insurance in “Remarks” section below)
- ☐ Other (explain in “Remarks” section below)

CHANGES TO EXISTING COVERAGE

Change to:
☐ Individual ☐ Family ☐ Other
- ☐ Addition of a dependent (complete “Dependent” section above)
- ☐ Change in name, address, or other application information (give previous information in “Remarks” section below)
- ☐ COBRA
- ☐ Other (explain in “Remarks” section below)

REMARKS

AGREEMENT (SUBSCRIBER'S SIGNATURE)

I agree to the terms and conditions located on the back of this form.

X ____________________

For Office Use Only | Territory | Receipt Date | Employer’s Signature | Date

Benefits Administrator: Mail white and yellow copies to FCHP Service Operations, 10 Chestnut St., Worcester, MA 01608. Pink copy is for employee.
FCHP cannot process this form without authorized signature from employer.

Temporary Membership Card

WELCOME! Thank you for choosing The Employee Advantage for your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information on your membership in The Employee Advantage and your membership card(s). In the meantime, this sheet is your **temporary membership card.** Also included in this kit will be information on how to obtain The Employee Advantage *Member Handbook/Evidence of Coverage*, which defines your benefits and regulates benefit decisions. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with The Employee Advantage Group Agreement and the The Employee Advantage *Member Handbook/ Evidence of Coverage*.

CHOOSING YOUR PHYSICIAN: At the time of enrollment, you also must select a primary care physician for every person covered under this contract: a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to TheEmployeeAdvantage.org or The Employee Advantage *Provider Network* directory for a complete list of providers and their locations. You must make these selections now and list your choices on this Membership Transaction Form. If you wish to notify us of a physician change or if you need help choosing a physician, please call the Customer Service Department at 1-877-498-1188 (TTY users, please call TRS Relay 711). To make an appointment, call your doctor's office or medical center directly.

EMERGENCY CARE: *Emergency services do not require referral or authorization.* When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). If you receive care outside of the plan service area, The Employee Advantage requires you to notify the plan within 48 hours or as soon as is medically possible. For more information on emergency benefits and plan procedures for emergency services, consult The Employee Advantage *Member Handbook/Evidence of Coverage*.

OUT-OF-AREA CARE: When you are out of the service area, you are covered for any unexpected illness or injury that needs prompt medical attention. Call The Employee Advantage Customer Service at 1-877-498-1188 (TTY users, please call TRS Relay 711) to report use of services, and call your doctor to arrange for follow-up care.

REMEMBER: The Employee Advantage will not pay for any services that are not provided or appropriately arranged by The Employee Advantage, except in life-threatening emergencies in the area or any emergencies out of the service area.

CONSENT: Submission of this form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation, processing and payment of related claims.

AGREEMENT: I am employed by the company named on this form, working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage (or I am otherwise eligible for the named company's health insurance coverage, e.g., as a former employee covered under COBRA). I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for The Employee Advantage coverage I have selected. I understand that The Employee Advantage is a health maintenance organization and that membership becomes effective in accordance with The Employee Advantage Group Agreement and The Employee Advantage *Member Handbook/Evidence of Coverage*. I have read this Membership Transaction Form and understand how to obtain and use services under The Employee Advantage coverage. I certify that all information is correct to the best of my knowledge.

QUESTIONS ABOUT COVERAGE? Call The Employee Advantage Customer Service at 1-877-498-1188 (TTY users, please call TRS Relay 711), or visit our Web site at TheEmployeeAdvantage.org.