Member Transaction Form

Please print clearly and complete all applicable fields.

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

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

Group number	Group name	Effective date: MM/DD/YYYY

Type of coverage: ☐ Individual ☐ Two-person ☐ Family ☐ Other _____

Provider network: ☐ FCHP Direct Care* ☐ FCHP Select Care ☐ Fallon Preferred Care ☐ FCHP Steward Community Care* ☐ FCHP Tiered Choice*

Plan name: _____

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 ☐ Two-person 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

☐ 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.

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

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

Physical address		
City	State	ZIP code

Mailing address *(if different from physical above)*		
City	State	ZIP code

Would you be interested in receiving communications from FCHP via e-mail? If so, please check the box and provide your e-mail address: ☐	Home phone

Social Security #	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 physician (PCP). Are you currently being treated by this PCP? ☐ Yes ☐ No

First name MI Last name

Benefits administrator: Please mail the white and yellow copies of this form to: FCHP Service Operations, 10 Chestnut St., Worcester, MA 01608.

The pink copy is for the employee.

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 #

Primary language | Race | Birth date (MM/DD/YYYY)

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this 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 #

Primary language | Race | Birth date (MM/DD/YYYY)

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this 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 #

Primary language | Race | Birth date (MM/DD/YYYY)

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this 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 #

Primary language | Race | Birth date (MM/DD/YYYY)

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this 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 #

Primary language | Race | Birth date (MM/DD/YYYY)

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this 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 | Print name here | Date

X _____ _____

Employer signature | Print name here | Date

Group name (please print) _____

* FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice provide access to networks that are smaller than the FCHP 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 fchp.org to determine which providers are included in FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice.

FCHP Tiered Choice members have access to network benefits only from the providers in FCHP Tiered Choice, and may pay different levels of copayments, coinsurance and/or deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on January 1.

Welcome!

Thank you for choosing us to provide your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information about your membership and your membership card(s). Also included in your New Member Kit will be information on how to obtain a *Member Handbook/Evidence of Coverage,* which defines your benefits and regulates benefit decisions. If you, or a dependent, need to seek medical services or fill a prescription before you receive your Member ID card in the mail, all you have to do is give us a call. A member of our Customer Service team can help you. Simply ask for the following information:

1. Your Member ID card number
2. If you need to fill a prescription, ask for your BIN number, and your PCN number.
   These are codes that your pharmacy will need to ensure that your drugs are covered, and that you pay the right out-of-pocket cost-sharing amount.

If you are an FCHP Direct Care, FCHP Select Care, FCHP Steward Community Care or an FCHP Tiered Choice plan member:

You must choose a primary care physician (PCP):
Each person covered under one of these contracts must choose a PCP. A PCP is a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to fchp.org or your plan's *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. Informing FCHP of your PCP selection(s) as soon as possible will help ensure that any bills for health services you receive from your PCP are processed as quickly as possible.

Worldwide 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). For more information on emergency benefits and plan procedures for emergency services, consult your *Member Handbook/Evidence of Coverage*.

Out-of-area urgent care: When you are out of the service area, you are covered for any unexpected illness or injury that needs prompt medical attention and can go to the nearest medical facility for care. You will need to contact your PCP to coordinate all follow-up care, including any additional care you require outside of the service area.

Remember: FCHP will not pay for any services that are not provided or appropriately arranged by Fallon Community Health Plan, except in life-threatening emergencies in the area or any emergencies out of the service area.

Questions? Call FCHP Customer Service at 1-800-868-5200 (TTY users, please call TRS Relay 711), or visit our Web site at fchp.org.

If you are a Fallon Preferred Care PPO plan member:

Fallon Preferred Care is a preferred provider organization (PPO) plan that offers you access to a network of more than 600,000 participating providers across the country. The network of participating providers includes the Private Healthcare Systems (PHCS) network as well as the Fallon Preferred Care providers. PHCS has created one of the largest proprietary PPO networks in the country, and received endorsements of quality from both the National Committee for Quality Assurance and URAC. You may elect to obtain health care services, including specialty care, from any provider with no referral requirements. However, you may need to receive prior authorizations from the Plan for certain services. Additionally, when you seek care out of the network, you will share a larger portion of the cost.

Worldwide 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 are admitted, Fallon Preferred Care requires that you notify FCHP within 72 hours or as soon as medically possible. For more information on benefits and procedures for emergency services, consult your Fallon Preferred Care *Member Handbook/Evidence of Coverage.*

Questions? Call Fallon Preferred Care Customer Service at 1-888-468-1541 (TTY users, please call TRS Relay 711) or visit our Web site at fchp.org.

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 FCHP/FHLAC coverage I have selected. I understand that FCHP is a Health Maintenance Organization (Fallon Preferred Care is a Preferred Provider Organization) and that membership becomes effective in accordance with the FCHP/FHLAC Group Agreement and the *Member Handbook/Evidence of Coverage*. I have read this Member Transaction Form and understand how to obtain and use services under my FCHP/FHLAC coverage. I certify that all information is correct to the best of my knowledge. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the FCHP/FHLAC Group Agreement and your plan's *Member Handbook/Evidence of Coverage*.