



GROUP INFORMATION

GROUP NUMBER \_\_\_\_\_

GROUP NAME  
**Teamsters Local 170**

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 below)  
 Change in name, address, or other application information (give previous information in "Remarks" section below)  
 Other (explain in "Remarks" section below)

EMPLOYEE INFORMATION

NAME (LAST/FIRST/MI) \_\_\_\_\_ MAIDEN NAME (IF APPLICABLE) \_\_\_\_\_ SEX  M  F FCHP IDENTIFICATION NUMBER \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_ AVERAGE NO. HOURS WORKED \_\_\_\_\_ DEPARTMENT # \_\_\_\_\_ EMPLOYEE # \_\_\_\_\_ IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: MO DAY YR

\*E-MAIL \_\_\_\_\_ PLEASE WRITE IN YOUR PERSONAL PHYSICIAN SELECTION \_\_\_\_\_ EVER TREATED BY THIS PHYSICIAN? (IF YES, UNDER WHAT NAME?)  YES  NO PHYSICIAN CODE \_\_\_\_\_ MEDICAL RECORD NUMBER \_\_\_\_\_

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

DEPENDENT INFORMATION

NAMES OF DEPENDENTS NAME (LAST/FIRST/MI)—MAIDEN NAME (IF APPLICABLE)	BIRTHDATE MO DAY YR	RELATION HUS WIFE SON DAU	SOCIAL SECURITY NUMBER	PRIMARY LANGUAGE	*E-MAIL	PERSONAL PHYSICIAN SELECTION (SEE PROVIDER LIST)	EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	FOR FCHP USE ONLY - MEDICAL RECORD NUMBER	
								PHYSICIAN CODE	LOCATION CODE
NAME (LAST/FIRST/MI)	MO DAY YR	SON DAU				PERSONAL PHYSICIAN SELECTION	<input type="checkbox"/> YES <input type="checkbox"/> NO	M.R.	L.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON DAU				PERSONAL PHYSICIAN SELECTION	<input type="checkbox"/> YES <input type="checkbox"/> NO	M.R.	L.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON DAU				PERSONAL PHYSICIAN SELECTION	<input type="checkbox"/> YES <input type="checkbox"/> NO	M.R.	L.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON DAU				PERSONAL PHYSICIAN SELECTION	<input type="checkbox"/> YES <input type="checkbox"/> NO	M.R.	L.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON DAU				PERSONAL PHYSICIAN SELECTION	<input type="checkbox"/> YES <input type="checkbox"/> NO	M.R.	L.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON DAU				PERSONAL PHYSICIAN SELECTION	<input type="checkbox"/> YES <input type="checkbox"/> NO	M.R.	L.C.

REMARKS

AGREEMENT

I, the undersigned, am employed by the above named company working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage. I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the Fallon Community Health Plan coverage I have selected. I understand that FCHP is a health maintenance organization and that membership becomes effective in accordance with the FCHP Group Agreement and the FCHP Select Care Member Handbook/Evidence of Coverage. I have read the back of this Membership Transaction Form and understand how to obtain and use services under my FCHP coverage. I certify that all information is correct to the best of my knowledge.

FOR FCHP USE ONLY

REASON CODE  
A \_\_\_\_\_ T \_\_\_\_\_

TERRITORY \_\_\_\_\_ RECEIPT DATE \_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

EMPLOYER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# TEMPORARY MEMBERSHIP CARD

**WELCOME TO FALLON COMMUNITY HEALTH PLAN!** Thank you for choosing Fallon Community Health Plan (FCHP) for your health coverage. In a short time you will receive a New Member Kit in the mail. This kit will include information on your membership in Fallon Community Health Plan and your membership card(s). In the meantime, this sheet is your **temporary membership card**. Also included in this kit will be a *Member Handbook/Evidence of Coverage*, which defines your benefits and governs benefit decisions. **NOTE:** Requested effective date may not be actual effective date if it is not in accordance with the FCHP Group Agreement and the *Member Handbook/Evidence of Coverage*.

**SELECT CARE:** With FCHP Select Care, you may choose to receive care not only from the nationally renowned Fallon Clinic (FC), but also from thousands of physicians throughout our service area. Our providers are carefully chosen for their medical excellence and patient access, as well as their efficiency and innovation. **And if you select a Fallon Clinic primary care physician for your care, you can see any Fallon Clinic physician specialist\*—without a referral.**

**CHOOSING YOUR PHYSICIAN:** You must also select a personal physician at the time of enrollment 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 your provider 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 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

**MAKING APPOINTMENTS:** Call your doctor's office or medical center directly to schedule appointments.

**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, Fallon Community Health Plan 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 your *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 FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) to report use of services, and call your doctor to arrange for follow-up care.

**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.

**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, and processing and payment of related claims.

**QUESTIONS ABOUT COVERAGE?** Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or visit our Web site at [www.fchp.org](http://www.fchp.org).