

Fallon Preferred Care Member Transaction Form



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
BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	HOME PHONE () ()	WORK PHONE () ()	*E-MAIL		
DATE HIRED	AVERAGE NO. HOURS WORKED		DEPARTMENT #		EMPLOYEE #	
SOCIAL SECURITY NUMBER	RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> OTHER				IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: MO / DAY / YR	
DO YOU OR ANOTHER FAMILY MEMBER HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE GIVE NAME OF HEALTH PLAN _____					IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEPENDENT INFORMATION

NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)			<input type="checkbox"/> M <input type="checkbox"/> F		SOCIAL SECURITY NUMBER	
RELATION _____			BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	
*E-MAIL _____			RACE _____			
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)			<input type="checkbox"/> M <input type="checkbox"/> F		SOCIAL SECURITY NUMBER	
RELATION _____			BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	
*E-MAIL _____			RACE _____			
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)			<input type="checkbox"/> M <input type="checkbox"/> F		SOCIAL SECURITY NUMBER	
RELATION _____			BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	
*E-MAIL _____			RACE _____			
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)			<input type="checkbox"/> M <input type="checkbox"/> F		SOCIAL SECURITY NUMBER	
RELATION _____			BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	
*E-MAIL _____			RACE _____			
NAME OF DEPENDENT (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)			<input type="checkbox"/> M <input type="checkbox"/> F		SOCIAL SECURITY NUMBER	
RELATION _____			BIRTHDATE MO / DAY / YEAR		PRIMARY LANGUAGE	
*E-MAIL _____			RACE _____			

GROUP INFORMATION REASON FOR TRANSACTION

GROUP NUMBER	ADDING COVERAGE <input type="checkbox"/> New hire <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (explain in "Remarks" section below)		CHANGES TO EXISTING COVERAGE Change to: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other <input type="checkbox"/> Addition of a dependent (complete "Dependent" section above) <input type="checkbox"/> Change in name, address, or other application information (give previous information in "Remarks" section below) <input type="checkbox"/> COBRA <input type="checkbox"/> Other (explain in "Remarks" section below)	
GROUP NAME	ENDING COVERAGE <input type="checkbox"/> Termination of employment <input type="checkbox"/> Change to other insurance (give name of other insurance in "Remarks" section below) <input type="checkbox"/> Other (explain in "Remarks" section below)			
REQUESTED EFFECTIVE DATE MO / DAY / YEAR				
TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER _____				

REMARKS AGREEMENT (SUBSCRIBER'S SIGNATURE)

REMARKS			I have read the back of this Member Transaction Form and understand how to obtain and use services under my Fallon Preferred Care coverage. I certify that all information is correct to the best of my knowledge. X _____		
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For FCHP Use Only	Reason Code A T		Territory	Receipt Date	Employer's Signature		Date
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Temporary Membership Card

WELCOME TO FALLON PREFERRED CARE! Thank you for choosing Fallon Preferred Care for your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information on your membership in Fallon Preferred Care 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 a Member Handbook/*Evidence of Coverage*, which defines your benefits and governs benefit decisions. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the Fallon Preferred Care Group Agreement and the Fallon Preferred Care *Evidence of Coverage*.

FALLON PREFERRED CARE: 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. In addition, there are no referral requirements. In general, if you choose to see a participating provider, you will enjoy a higher level of coverage. When you seek care out of the network, you will share a larger portion of the cost. The choice is yours. For more information on participating providers, you can visit fchp.org or you can contact a Fallon Preferred Care representative at 1-888-468-1541 (TDD/TTY: 1-877-608-7677).

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 American Health Holdings at 1-866-353-1787 within 72 hours or as soon as is medically possible. For more information on benefits and procedures for emergency services, consult your Fallon Preferred Care *Evidence of Coverage*.

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 named company 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 by COBRA). I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the Fallon Preferred Care coverage I have selected. I understand that Fallon Preferred Care is a Preferred Provider Organization (PPO) and that membership becomes effective in accordance with the Fallon Preferred Care Group Agreement and the Fallon Preferred Care *Evidence of Coverage*.

CONTACT INFORMATION: For questions regarding benefits, eligibility or plan procedures, please call Fallon Preferred Care Customer Service at 1-888-468-1541 (TDD/TTY: 1-877-608-7677), or visit our Web site at fchp.org. To reach American Health Holdings, please call 1-866-353-1787.