allways[sm] HEALTH PARTNERS

Enrollment and Change Form

399 Revolution Drive, Suite 940, Somerville, MA 02145

Tel 800-462-5449
Fax 617-526-1981

Please use a ball point pen and press down firmly.

Application for Enrollment	Change in Enrollment	Reason for Change in Enrollment	
☐ New employee	☐ Add dependents	☐ Marriage	☐ Add disabled dependents
☐ Annual enrollment	☐ Remove dependents	☐ Birth of child	☐ Moved out of service area
☐ COBRA Continuation	☐ PCP/Site change	☐ Adoption of child*	☐ Voluntary
☐ Involuntary loss of prior group coverage*	☐ Termination	☐ Divorce	☐ Loss of dependent eligibility
☐ Other ______	☐ Employee/dependent demographics	☐ Left employment	☐ Death, exact date ______
Documentation required	☐ Other ______	☐ Reached age 65	

Group Information

AllWays Health Partners group number	Employer name: BeneTemps, Inc. dba BTHR Solutions
Date of employment Month / Day / Year	Effective Date Month / Day / Year — Plan design: AllWays Complete HMO HSA 2500

Intermediary
☐ Group
☐ Non-group

Employee Information

Last name	First name	M.I.		
Date of birth (mm/dd/yy)	Social Security Number ___ - __ - ____	Gender (m/f)	Home phone – *Include area code*	Email address
Street mailing address	Apt.	P.O. Box	City	State / Zip code

PCP and Site Information

For help finding a PCP in our network, please go to allwayshealthpartners.org and search our Find a Doctor tool.
You may change your PCP at any time.

Primary care site	
Your Primary Care Physician (Last name, First, M.I.)	Existing patient? ☐ Yes ☐ No

Language

What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐ English ☐ Spanish ☐ Cantonese ☐ Cape Verdean Creole ☐ French ☐ Haitian Creole ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Vietnamese ☐ Other, please specify______

Group Coverage

Type of AllWays Health Partners coverage (check only one)	In addition to AllWays Health Partners, my spouse or children are covered by a health plan offered by:			
☐ Self ☐ Individual & spouse ☐ Individual & child/children ☐ Family	Employer	Insurance co. name	Policy #	Effective date

Are you and/ or your spouse eligible for Medicare?				
	Self ☐ Yes ☐ No	If yes, are you enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your Medicare policy number
	Spouse ☐ Yes ☐ No	If yes, is your spouse enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your spouse's Medicare policy number

Please provide **ALL** information below for any eligible dependents you wish to enroll.

Spouse last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___ - __ - ____	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___ - __ - ____	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___ - __ - ____	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___ - __ - ____	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** ___ - __ - ____	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

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 atención 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).

All information must be completed and form signed before processing can begin

Employee's signature: ______________________ Date: __________

Employer contact

Return white original to AllWays Health Partners — Yellow copy to employer — Pink copy to employee