allways HEALTH PARTNERS

PPO Plus Enrollment and Change Form

399 Revolution Drive, Suite 940, Somerville, MA 02145

Tel 866-414-5533
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	☐ Adding dependents	☐ Marriage	☐ Reached age 65
☐ Annual enrollment	☐ Remove dependents	☐ Birth of child	☐ Adding disabled dependents
☐ COBRA Continuation	☐ Termination	☐ Adoption of child*	☐ Voluntary
☐ Involuntary loss of prior group coverage*	☐ Employee/dependent demographics	☐ Divorce	☐ Loss of dependent eligibility
☐ Other ____	☐ Other ____	☐ Left employment	☐ Death, exact date ____

**Documentation required*

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 PPO HSA 2500

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

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 (04) ☐ Spanish (14) ☐ French (05) ☐ Haitian Creole (06) ☐ Portuguese (12) ☐ Russian (13) ☐ Cape Verdean Creole (03) ☐ Cantonese (02) ☐ Mandarin (11) ☐ Vietnamese (15) ☐ Other (16), please specify____________

Group Coverage

Type of AllWays Health Partners coverage (check only one)

☐ Self ☐ Individual & spouse ☐ Individual & child/children ☐ Family

In addition to AllWays Health Partners, my spouse or children are covered by a health plan offered by:

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 the information below for any eligible dependents you wish to enroll. (Primary care site and provider are optional.)

Spouse last name		First name		M.I.	Primary care site (OPTIONAL)	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary Care Provider (Last name, First name, M.I.) (OPTIONAL)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site (OPTIONAL)	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary Care Provider (Last name, First name, M.I.) (OPTIONAL)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site (OPTIONAL)	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary Care Provider (Last name, First name, M.I.) (OPTIONAL)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site (OPTIONAL)	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary Care Provider (Last name, First name, M.I.) (OPTIONAL)	☐ Yes ☐ No
Dependent last name		First name		M.I.	Primary care site (OPTIONAL)	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary Care Provider (Last name, First name, M.I.) (OPTIONAL)	☐ 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, worker's compensation plan or other coverage. I (we) agree that AllWays Health Partners and its affiliated PPO network 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. For further information on how AllWays Health Partners may use your information, refer to AllWays Health Partners' Notice of Privacy Practices.

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

Employee's signature: ______________________ Date: __________

Employer contact name (please print): ______________ Phone: __________ Employer's signature: ______________________ Date: __________

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