HOMETOWN HEALTH USE ONLY

G# _____

M# _____

L _____

F, M _____

Hometown Health

IFP ENROLLMENT / CHANGE FORM

SUBSCRIBER INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____

City _____ State _____ Zip _____ County _____

Physical Address _____

City _____ State _____ Zip _____ County _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone _____ Work Phone _____

PLAN ELECTED

*Street Address only, no P.O. Boxes

☐ HMO	☐ EPO	☐ PPO	☐ PPO w/HSA*
Plan Elected	**Plan Elected**	**Plan Elected**	**Plan Elected**
_____	_____	_____	_____
_____	_____	_____	_____

OTHER MEDICAL COVERAGE

Do you or any of your Dependents listed on the next page have Medical/Health Insurance (Including Medicare/Medicaid)?

☐ ***YES*** ☐ ***NO***

If yes, please provide copy of insurance card (front & back).

ADD/DELETE DEPENDENT

☐ Marriage**	☐ Divorce**	☐ Birth/Adoption**	☐ Other**
☐ Loss of Dependent Status**	☐ Court Ordered/ Legal Guardianship**	☐ Loss of Insurance**	☐ Deceased**

***Attach legal documentation as proof of event.*

MEMBER INFORMATION – COMPLETE WITH NEW OR CHANGE INFORMATION

SUBSCRIBER **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ________ First Name ________ Middle Initial ________

Social Security Number ________ Date of Birth (mm/dd/yyyy) ________

Sex ☐ Male ☐ Female

Email Address ________ Primary Care Physician *(if required)*† ________

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ________

SPOUSE **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ________ First Name ________ Middle Initial ________

Social Security Number ________ Date of Birth (mm/dd/yyyy) ________

Sex ☐ Male ☐ Female **Reside with Subscriber?** ☐ ***YES*** ☐ ***NO***

Email Address ________ Primary Care Physician *(if required)*† ________

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ________

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ________ First Name ________ Middle Initial ________

Social Security Number ________ Date of Birth (mm/dd/yyyy) ________

Sex ☐ Male ☐ Female **Reside with Subscriber?** ☐ ***YES*** ☐ ***NO***

Email Address ________ Primary Care Physician *(if required)*† ________

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ________

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ________ First Name ________ Middle Initial ________

Social Security Number ________ Date of Birth (mm/dd/yyyy) ________

Sex ☐ Male ☐ Female **Reside with Subscriber?** ☐ ***YES*** ☐ ***NO***

Email Address ________ Primary Care Physician *(if required)*† ________

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ________

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ________ First Name ________ Middle Initial ________

Social Security Number ________ Date of Birth (mm/dd/yyyy) ________

Sex ☐ Male ☐ Female **Reside with Subscriber?** ☐ ***YES*** ☐ ***NO***

Email Address ________ Primary Care Physician *(if required)*† ________

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ________

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ________ First Name ________ Middle Initial ________

Social Security Number ________ Date of Birth (mm/dd/yyyy) ________

Sex ☐ Male ☐ Female **Reside with Subscriber?** ☐ ***YES*** ☐ ***NO***

Email Address ________ Primary Care Physician *(if required)*† ________

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ________

***Attach legal documentation as proof of action (Add, Change or Delete).*
† It is member's responsibility to verify physician availability in their area.

ACKNOWLEDGMENT OF TERMS

Subscriber Signature ________ Date ________

See Next Page

Hometown Health

ACKNOWLEDGMENT OF TERMS

I understand and agree that, with the exception of emergency procedures, all services must be performed by a Hometown Health participating provider, or authorized in advance by Hometown Health, to be considered for payment at the in-network rate. Additional requirements may apply. See the appropriate plan documents for details.

I understand that I am responsible for paying any required deductibles, copayments, and coinsurance directly to the providers of healthcare at the time of service.

I agree to be bound by all terms of the plan under which I am applying for coverage for as long as I am covered under the plan.

I certify that, to the best of my knowledge, the information shown on the front of this form is correct.

I have read and understand the terms of this application.

My signature on the front of this form constitutes acceptance of the terms listed above.

Key to Plan Types

HMO Health Maintenance Organization
PPO Preferred Provider Organization
TPA Third Party Administrator for self-funded plan
HSA Health Savings Account

STATEMENT OF ACCOUNTABILITY

To be completed only when the applicant cannot complete the application
NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English
☐ Applicant does not write English ☐ Other *(Explain)* _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant ☐ Or by _____

I also translated and fully explained the "Application Understandings, Conditions and Agreement," and "Payment Method."

Translator Signature *(Required)* _____ Date *(Required)* _____

I confirm that the application was translated on my behalf.

Applicant Signature *(Required)* _____ Date *(Required)* _____
Language interpreted *(e.g. Spanish)* _____

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