

The Harvard Pilgrim HMO

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 www.harvardpilgrim.org

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

- | | | |
|---|---|--|
| <input type="checkbox"/> ENROLLMENT | <input type="checkbox"/> CHANGE | <input type="checkbox"/> TERMINATION |
| <input type="checkbox"/> NEW HIRE | <input type="checkbox"/> CHANGE COVERAGE TYPE | <input type="checkbox"/> LEFT EMPLOYMENT |
| <input type="checkbox"/> ANNUAL OPEN ENROLLMENT | <input type="checkbox"/> ADD DEPENDENT LISTED BELOW | <input type="checkbox"/> NO LONGER ELIGIBLE |
| <input type="checkbox"/> LOSS OF INSURANCE DATE _____
(ATTACH DOCUMENTS) | <input type="checkbox"/> TERMINATE DEPENDENT LISTED BELOW | <input type="checkbox"/> VOLUNTARY CANCELLATION |
| <input type="checkbox"/> P/T TO F/T DATE _____ | <input type="checkbox"/> NAME/ADDRESS CHANGE | <input type="checkbox"/> DECEASED DATE _____ |
| | <input type="checkbox"/> LOSS OF INSURANCE DATE _____
(ATTACH DOCUMENTS) | <input type="checkbox"/> MOVED FROM SERVICE AREA |
| | <input type="checkbox"/> MARRIAGE DATE _____ | |
| | <input type="checkbox"/> NEWBORN DATE _____ | |

TO BE COMPLETED BY HPHC ONLY.	GROUP / COMPANY NAME	DATE OF HIRE	GROUP #/DIVISION	EFFECTIVE DATE
H P				
EMPLOYEE NAME		TYPE OF COVERAGE		
FIRST	MIDDLE	LAST	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 2-PERSON (ONLY WHERE OFFERED) <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER	
HOME ADDRESS		PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK 02—SPOUSE/CIV UN 03—CHILD UNDER 19, CHILD TAX DEP 19-25 (MA ONLY), CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY), CHILD UP TO 26 (NH ONLY) 04—STEPCHILD UNDER 19 05*—FULL-TIME STUDENT 19 AND OVER 06—HANDICAPPED (VERIF REQ) 07—EX-SPOUSE		
APT. NO.	STREET			
CITY	STATE	ZIP	IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN. AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.	
TELEPHONE (HOME)	TELEPHONE (WORK)			
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FIRST	MI	LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?	PCP#
MO	DAY	YR						Y	N	
EMPLOYEE				-	-		- -		Y	N
SPOUSE				-	-		- -		Y	N
DEPENDENT				-	-		- -		Y	N
DEPENDENT				-	-		- -		Y	N
DEPENDENT				-	-		- -		Y	N
DEPENDENT				-	-		- -		Y	N

LANGUAGE CODES (OPTIONAL)

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS American Sign Language
 CA Cantonese
 CV Cape Verdean
 EN English
 FR French
 HA Haitian
 HM Hmong
 IT Italian
 KH Khmer
 LO Laotian
 MN Mandarin
 PT Portuguese
 RU Russian
 SP Spanish
 VI Vietnamese
 OTHER _____ Specify

* IF YOU HAVE LISTED A FULL-TIME STUDENT(S) AGE 19 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION: STUDENT(S) NAME _____ NAME OF SCHOOL(S) _____ STATE _____ _____ _____ THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY	HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE. E-MAIL ADDRESS: _____ (OPTIONAL) YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.
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MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. FOR AN EXPLANATION OF HOW HARVARD PILGRIM MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HARVARD PILGRIM IN YOUR ENROLLMENT KIT.
 MAINE MEMBERS: PLEASE NOTE THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS.
 I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

THE EMPLOYEE AND THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

_____ EMPLOYEE SIGNATURE	_____ DATE	_____ EMPLOYER SIGNATURE	_____ DATE
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