

# The Harvard Pilgrim HMO

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## REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> <b>ENROLLMENT</b>                                  | <input type="checkbox"/> <b>CHANGE</b>                                      | <input type="checkbox"/> <b>TERMINATION</b>      |
| <input type="checkbox"/> NEW HIRE   | <input type="checkbox"/> COBRA  | <input type="checkbox"/> LEFT EMPLOYMENT         |
| <input type="checkbox"/> ANNUAL OPEN ENROLLMENT                             | <input type="checkbox"/> CHANGE COVERAGE TYPE                               | <input type="checkbox"/> NO LONGER ELIGIBLE      |
| <input type="checkbox"/> LOSS OF INSURANCE DATE _____<br>(ATTACH DOCUMENTS) | <input type="checkbox"/> ADD DEPENDENT LISTED BELOW                         | <input type="checkbox"/> VOLUNTARY CANCELLATION  |
| <input type="checkbox"/> P/T TO F/T DATE _____                              | <input type="checkbox"/> TERMINATE DEPENDENT LISTED BELOW                   | <input type="checkbox"/> DECEASED DATE _____     |
|   | <input type="checkbox"/> NAME/ADDRESS CHANGE                                | <input type="checkbox"/> MOVED FROM SERVICE AREA |
|   | <input type="checkbox"/> LOSS OF INSURANCE DATE _____<br>(ATTACH DOCUMENTS) | <input type="checkbox"/> MARRIAGE DATE _____     |
|   | <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
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EMPLOYEE NAME <b>FIRST</b> _____ <b>MIDDLE</b> _____ <b>LAST</b> _____ ADDRESS APT. NO. _____ STREET _____ PO BOX _____ CITY _____ STATE _____ ZIP _____ COUNTY _____ TELEPHONE (HOME) ( ) _____ TELEPHONE (WORK) ( ) _____	TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 2-PERSON (ONLY WHERE OFFERED) <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER _____
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**PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK**

02 SPOUSE 03 CHILD UNDER 19 03 CHILD TAX DEPENDENT 19-25 (MA ONLY) 03 CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY)  
 04 STEPCCHILD UNDER 19 05' FULL-TIME STUDENT 19 AND OVER 06 HANDICAPPED (VERIFICATION REQUIRED) 07 EX-SPOUSE

**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.

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		-	-		M	F	01	-	-	Y	N	
SPOUSE		-	-		M	F		-	-	Y	N	
DEPENDENT		-	-		M	F		-	-	Y	N	
DEPENDENT		-	-		M	F		-	-	Y	N	
DEPENDENT		-	-		M	F		-	-	Y	N	
DEPENDENT		-	-		M	F		-	-	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.  
 NEW HAMPSHIRE MEMBERS: PLEASE NOTE THAT AN ENROLLED PARTICIPANT SHALL BE ALLOWED A GRACE PERIOD OF TEN (10) DAYS FOR MAKING ANY PAYMENT DUE UNDER CONTRACT (N.H. RSA 420-B:8(IV)(b)).  
 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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