

The Harvard Pilgrim HMO
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- REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)**
- ENROLLMENT**
 - CHANGE**
 - TERMINATION**
 - NEW HIRE
 - COBRA
 - CHANGE COVERAGE TYPE
 - NAME/ADDRESS CHANGE
 - LEFT EMPLOYMENT
 - NO LONGER ELIGIBLE
 - ANNUAL OPEN ENROLLMENT
 - ADD DEPENDENT LISTED BELOW
 - LOSS OF INSURANCE DATE (ATTACH DOCUMENTS LISTED BELOW)
 - TERMINATE DEPENDENT
 - MARRIAGE DATE
 - VOLUNTARY CANCELLATION
 - DECEASED DATE
 - LOSS OF INSURANCE DATE (ATTACH DOCUMENTS LISTED BELOW)
 - MARRIAGE DATE
 - NEWBORN DATE
 - P/T TO F/T DATE

TO BE COMPLETED BY HPHC ONLY. GROUP / COMPANY NAME: _____ DATE OF HIRE: _____ GROUP # / DIVISION: _____ EFFECTIVE DATE: _____

HPHC EMPLOYEE NAME: _____ MIDDLE: _____ LAST: _____

ADDRESS: _____ STREET: _____ STATE: _____ ZIP: _____ CITY: _____ COUNTY: _____ PO BOX: _____

TELEPHONE (HOME): _____ TELEPHONE (WORK): _____

APR. NO. _____

TELEPHONE (HOME): _____ TELEPHONE (WORK): _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION CHECK.

02 SPOUSE 03 CHILD UNDER 19 04 CHILD TAX DEPENDENT 19-25 (MA ONLY) 05 CHILD 19-25 TAX DEPT YR EXTN (MA ONLY)
 06 STEPCHILD UNDER 19 07 FULL-TIME STUDENT 19 AND OVER 08 HANDICAPPED (VERIFICATION REQUIRED) 09 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	MO	DATE OF BIRTH DAY	YR	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#
EMPLOYEE						M	F 01				
SPOUSE						M	F				
DEPENDENT						M	F				
DEPENDENT						M	F				
DEPENDENT						M	F				
DEPENDENT						M	F				

LANGUAGE CODES (OPTIONAL)

AS American Sign Language CA Cantonese CV Cape Verdean EN English FR French HA Haitian HM Hmong IT Italian KH Khmer LO Laoian 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: _____

HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? YES 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)

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY.

YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.

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 (H.H. ISA 420-B:81(V)(b)).

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: _____

10/06 001-11 HMO WHITE - HARVARD PILGRIM COPY YELLOW - EMPLOYER COPY PINK - EMPLOYEE COPY