

The Harvard Pilgrim HMO

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REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

ENROLLMENT

- NEW HIRE COBRA
 ANNUAL OPEN ENROLLMENT
 LOSS OF INSURANCE DATE _____
 (ATTACH DOCUMENTS)
 P/T TO F/T DATE _____

CHANGE

- CHANGE COVERAGE TYPE NAME/ADDRESS CHANGE
 ADD DEPENDENT LISTED BELOW LOSS OF INSURANCE DATE _____
 (ATTACH DOCUMENTS)
 TERMINATE DEPENDENT LISTED BELOW
 MARRIAGE DATE _____
 NEWBORN DATE _____

TERMINATION

- LEFT EMPLOYMENT NO LONGER ELIGIBLE
 VOLUNTARY CANCELLATION DECEASED DATE _____
 MOVED FROM SERVICE AREA

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| TO BE COMPLETED BY HPHC ONLY. | | GROUP / COMPANY NAME | DATE OF HIRE | GROUP #/DIVISION | EFFECTIVE DATE |
| H P _____ EMPLOYEE NAME | | TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 2-PERSON (ONLY WHERE OFFERED) <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER | | | |
| FIRST _____ MIDDLE _____ LAST _____ ADDRESS APT. NO. _____ STREET _____ PO BOX _____ CITY _____ STATE _____ ZIP _____ COUNTY _____ | | PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK | | | |
| TELEPHONE (HOME) _____ () _____ | | TELEPHONE (WORK) _____ () _____ | | 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 MO 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 | - - - | | 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 | |

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| 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. | | | | | | | | | | | | | | |
| | <input type="checkbox"/> AS American Sign Language | <input type="checkbox"/> CA Cantonese | <input type="checkbox"/> CV Cape Verdean | <input type="checkbox"/> EN English | <input type="checkbox"/> FR French | <input type="checkbox"/> HA Haitian | <input type="checkbox"/> HM Hmong | <input type="checkbox"/> IT Italian | <input type="checkbox"/> KH Khmer | <input type="checkbox"/> LO Laotian | <input type="checkbox"/> MN Mandarin | <input type="checkbox"/> PT Portuguese | <input type="checkbox"/> RU Russian | <input type="checkbox"/> SP Spanish | <input type="checkbox"/> VI Vietnamese |

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| <p>* IF YOU HAVE LISTED A FULL-TIME STUDENT(S) AGE 19 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION:</p> <p>STUDENT(S) NAME _____ NAME OF SCHOOL(S) _____ STATE _____</p> <p>_____</p> <p>_____</p> <p>THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY</p> | <p>HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.</p> <p>E-MAIL ADDRESS: _____ (OPTIONAL)</p> <p>YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.</p> |
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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(V)(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 DEFAUDING 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.

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|-----------------------------|---------------|-----------------------------|---------------|
| _____ EMPLOYEE SIGNATURE | _____ DATE | _____ EMPLOYER SIGNATURE | _____ DATE |
|-----------------------------|---------------|-----------------------------|---------------|