

The Harvard Pilgrim HMO Enrollment/Change Form

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www.harvardpilgrim.org

- REASON FOR SUBMISSION** (Please check all that apply)
- ENROLLMENT
 - CHANGE
 - TERMINATION
 - NEW HIRE
 - LOSS OF INSURANCE
 - NO LONGER ELIGIBLE
 - ANNUAL OPEN ENROLLMENT (ATTACH DOCUMENTS)
 - ADD DEPENDENT LISTED BELOW
 - LOSS OF INSURANCE
 - VOLUNTARY CANCELLATION
 - DECEASED DATE _____
 - COBRA
 - TERMINATE DEPENDENT LISTED BELOW
 - MOVED FROM SERVICE AREA
 - PT TO FT DATE _____
 - MARRIAGE DATE _____
 - OTHER _____

To be completed by HPHC only.

CONTRACT / ID NUMBER _____ GROUP / COMPANY NAME _____ DATE OF HIRE _____ DIVISION _____ EFFECTIVE DATE _____

EMPLOYEE NAME FIRST MIDDLE LAST _____

ADDRESS STREET _____ APT. NO. _____ PO BOX _____ COUNTY _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (HOME) _____ TELEPHONE (WORK) _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE 03 UNMARRIED CHILD UNDER 19 04 UNMARRIED STEPCHILD UNDER 19
05 * UNMARRIED FULL-TIME STUDENT OVER AGE 19 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.

SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER

EMPLOYEE	FIRST MI. LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	MO	DATE OF BIRTH DAY	YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	ARE YOU A PATIENT OF THIS DOCTOR?	POP#
EMPLOYEE						M	F 01			
SPOUSE						M	F			
DEPENDENT						M	F			
DEPENDENT						M	F			
DEPENDENT						M	F			
DEPENDENT						M	F			

LANGUAGE 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.

CODES (Optional) 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) OVER AGE 19 BUT UNDER THE MAXIMUM STUDENT AGE, SUPPLY THE FOLLOWING INFORMATION: NAME OF SCHOOL(S) _____

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.

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY.

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, OBTAINED 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 (NH, RSA 420-B:3(d)(v)).

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, SPOUSE AND ALL DEPENDENTS AGE 18 YEARS AND OVER MUST SIGN THIS FORM FOR ENROLLMENT.

EMPLOYEE SIGNATURE _____ DATE _____

DEPENDENT SIGNATURE (age 18 years - over) _____ DATE _____

SPOUSE SIGNATURE (if applicable) _____ DATE _____

DEPENDENT SIGNATURE (age 18 years - over) _____ DATE _____

EMPLOYER SIGNATURE _____ DATE _____

EMPLOYER SIGNATURE _____ DATE _____