The Harvard Pilgrim HMO Enrollment/Change Form

PO BOX 9185 • QUINCY, MA 02269
1-888-333-HPHC
www.harvardpilgrim.org

REASON FOR SUBMISSION (Please check all that apply)

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

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

☐ **TERMINATION**
☐ LEFT EMPLOYMENT
☐ NO LONGER ELIGIBLE
☐ VOLUNTARY CANCELLATION
☐ DECEASED DATE _____
☐ MOVED FROM SERVICE AREA
☐ OTHER _____

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

EMPLOYEE NAME
FIRST **MIDDLE** **LAST**

ADDRESS
APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )
TELEPHONE (WORK) ( )

TYPE OF COVERAGE
☐ INDIVIDUAL ☐ 2-PERSON (Only where offered) MARITAL STATUS _____
☐ FAMILY ☐ OTHER _____

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 AGE19 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 SPECIALITY 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	

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) OVER AGE 19 BUT UNDER THE MAXIMUM STUDENT AGE, SUPPLY THE FOLLOWING INFORMATION:

STUDENT(S) NAME NAME OF SCHOOL(S)

_____
_____
_____

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY

HAVE YOU EVER BEEN A MEMBER OF *Pilgrim Health Care,* Harvard Community Health Plan, HCHP OF NE, HPHC OR HPHC OF NE? ☐ 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)

THE E-MAIL MENU YOU RECEIVE MAY INCLUDE CHOICES SUCH AS; SECURE E-MAIL WITH YOUR PHYSICIAN, REPLACEMENT OF HPHC MAILINGS WITH E-MAILS POINTING TO OUR WEB-SITES, HEALTH-RELATED UPDATES AND REMINDERS, AND OTHER POSSIBLE OPTIONS. CONFIDENTIAL E-MAIL WILL BE SENT THROUGH A SECURE WEB-SITE, AND YOU WILL RECEIVE NOTIFICATION THAT THERE IS A MESSAGE FOR YOU AT THE SITE. NON-CONFIDENTIAL UPDATES AND REMINDERS YOU ELECT TO RECEIVE WILL BE SENT DIRECTLY TO THE E-MAIL ADDRESS LISTED ABOVE.

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

I UNDERSTAND THAT MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN AND THAT BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. I ALSO UNDERSTAND THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS. DURING MY MEMBERSHIP, I AUTHORIZE ANY HEALTH CARE PROVIDER OR OTHER HEALTH PLAN TO PROVIDE MEDICAL INFORMATION AND RECORDS TO THE PLAN, THE PLAN ADMINISTRATOR, OR PLAN AFFILIATED HEALTH CARE PROVIDERS. I ALSO AUTHORIZE THE PLAN, THE PLAN ADMINISTRATION, AND ANY PLAN HEALTH CARE PROVIDERS RENDERING SERVICES TO ME OR MY DEPENDENTS TO RECEIVE COPIES OF MY OR MY DEPENDENTS' MEDICAL RECORDS. I AUTHORIZE THE USE BY THE PLAN, AND ITS AGENTS, OF ANY INFORMATION OBTAINED HEREUNDER FOR THE DELIVERY OF HEALTH SERVICE, TO DETERMINE ELIGIBILITY AND ENTITLEMENT TO BENEFITS (INCLUDING REIMBURSEMENT BY THIRD PARTIES), FOR EDUCATION AND RESEARCH IN ACCORDANCE WITH GOVERNMENT REGULATIONS, AND FOR THE OTHER PLAN PROFESSIONAL ACTIVITIES SUCH AS UTILIZATION REVIEW, QUALITY ASSURANCE, CASE MANAGEMENT, REFERRAL AND AUTHORIZATION, DISEASE MANAGEMENT, FRAUD DETECTION AND CERTAIN OVERSIGHT ACTIVITIES, SUCH AS ACCREDITATION AND REGULATORY AUDITS. I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR TO MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.
NEW HAMPSHIRE BASED GROUPS PLEASE NOTE: THE ENROLLED PARTICIPANT SHALL BE ALLOWED A GRACE PERIOD OF TEN (10) DAYS FOR MAKING ANY PAYMENT DUE UNDER CONTRACT (RSA 420-B:8,IV(b)).

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	DEPENDENT SIGNATURE (age 18 years - over)	DATE
SPOUSE SIGNATURE (if applicable)	DATE	DEPENDENT SIGNATURE (age 18 years - over)	DATE	EMPLOYER SIGNATURE	DATE