

The Harvard Pilgrim HMO
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www.harvardpilgrim.org

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)
 CHANGE **COBRA** **NO LONGER ELIGIBLE**
 ENROLLMENT **NEW HIRE** **ANNUAL OPEN ENROLLMENT** **LOSS OF INSURANCE DATE** **DECEASED DATE**
 CHANGE COVERAGE TYPE **ADD DEPENDENT LISTED BELOW** **LOSS OF INSURANCE DATE** **TERMINATION**
 ADD DEPENDENT LISTED BELOW **TERMINATE DEPENDENT LISTED BELOW** **ATTACH DOCUMENTS** **ATTACH DOCUMENTS** **ATTACH DOCUMENTS** **ATTACH DOCUMENTS**
 PT TO FIT DATE **MARRIAGE DATE** **NEWBORN DATE** **YOUTHFUL CANCELLATION** **MOVED FROM SERVICE AREA**

TO BE COMPLETED BY HPHC ONLY. GROUP / COMPANY NAME: **WSHG. WALPOLE** EFFECTIVE DATE: **010105**

EMPLOYEE NAME: **H P** DATE OF HIRE: **05113135** GROUP # / DIVISION: **010105**

FIRST ADDRESS: **WSHG. WALPOLE** TYPE OF COVERAGE: INDIVIDUAL 2-PERSON (ONLY WHERE OFFERED) FAMILY OTHER

APT. NO. STREET STATE ZIP PO BOX COUNTY

TELEPHONE (HOME) TELEPHONE (WORK)

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 DEPT2 YR EXTN (MA ONLY)
 04 STEPCHILD 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. IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). MOST SPECIALTY CARE MAY NOT BE COVERED.

RELATION CODE	SEX	DATE OF BIRTH	LANGUAGE CODE	TELEPHONE (WORK)	STATE	ZIP	PO BOX	COUNTY	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	USE YOU A REGULAR PATIENT OF THIS DOCTOR?	PCP#
01	M	- - -		() () ()						Y	N
	F	- - -								Y	N
	M	- - -								Y	N
	M	- - -								Y	N
	M	- - -								Y	N
	M	- - -								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 [CVI] 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

* 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: _____ STATE: _____

NAME OF SCHOOL(S): _____

E-MAIL ADDRESS: _____ (OPTIONAL)

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.

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: _____