The Harvard Pilgrim PPO

PO BOX 9185 QUINCY, MA 02269
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www.harvardpilgrim.org

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
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW
- ☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS
- ☐ 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
	Wellesley College		0 4 0 9 2 8 —	

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)
☐ FAMILY ☐ OTHER _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02—SPOUSE **03**—CHILD UNDER 26 **06**—HANDICAPPED (VERIF REQ) **07**—EX-SPOUSE

FIRST MI LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER
EMPLOYEE		- -	M F	01	- -
SPOUSE		- -	M F		- -
DEPENDENT		- -	M F		- -
DEPENDENT		- -	M F		- -
DEPENDENT		- -	M F		- -
DEPENDENT		- -	M F		- -

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

ARE YOU CURRENTLY A MEMBER OF ANOTHER MEDICAL INSURANCE PLAN?
IF YES, PLEASE LIST OTHER MEDICAL PLAN(S) ON THE LINES BELOW.

_____
_____
_____

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY

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)

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 THAN 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