PLEASE CHOOSE PRODUCT: ☐ Value HMO ☐ HMO ☐ POS

Harvard Pilgrim

PO BOX 9185 • QUINCY, MA 02269
1-888-333-HPHC
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 To be completed by HR	EFFECTIVE DATE
H P	**Smith College**			

EMPLOYEE NAME
FIRST MIDDLE LAST

HOME 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 _____

Smith Employee ID#:
99 _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02—SPOUSE/CIV UN **03**—CHILD UNDER 19, CHILD TAX DEP 19-25 (MA ONLY), CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY), CHILD UP TO 26 (NH ONLY) **04**—STEPCHILD UNDER 19 **05***—FULL-TIME STUDENT 19 AND OVER **06**—HANDICAPPED (VERIF REQ **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.

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)**

THE FOLLOWING INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR SERVICE NEEDS. WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME

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

STUDENT(S) NAME **NAME OF SCHOOL(S)** **STATE**

_____

_____

_____

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