

The Harvard Pilgrim PPO Enrollment/Change Form

PO BOX 9185 • QUINCY, MA 02269

1-888-333-HPHC www.harvardpilgrim.org

Allianz Life is the Underwriter of out-of-network benefits for fully insured accounts.

REASON FOR SUBMISSION (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> ENROLLMENT | <input type="checkbox"/> CHANGE | <input type="checkbox"/> TERMINATION |
| <input type="checkbox"/> NEW HIRE | <input type="checkbox"/> CHANGE COVERAGE TYPE | <input type="checkbox"/> LEFT EMPLOYMENT |
| <input type="checkbox"/> ANNUAL OPEN ENROLLMENT (ATTACH DOCUMENTS) | <input type="checkbox"/> ADD DEPENDENT LISTED BELOW | <input type="checkbox"/> NO LONGER ELIGIBLE |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> TERMINATE DEPENDENT LISTED BELOW | <input type="checkbox"/> VOLUNTARY CANCELLATION |
| <input type="checkbox"/> P/T TO F/T DATE _____ | <input type="checkbox"/> MARRIAGE DATE _____ | <input type="checkbox"/> MOVED FROM SERVICE AREA |
| <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> DECEASED DATE _____ |
| | | <input type="checkbox"/> OTHER _____ |

To be completed by HPHC only.

CONTRACT / ID NUMBER		GROUP / COMPANY NAME		DATE OF HIRE		DIVISION		EFFECTIVE DATE																																																																																																										
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EMPLOYEE NAME				TYPE OF COVERAGE																																																																																																														
FIRST		MIDDLE		LAST		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 2-PERSON (Only where offered) <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER																																																																																																												
ADDRESS				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																																																																																																														
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<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th rowspan="2">RELATION CODE</th> <th rowspan="2">FIRST</th> <th rowspan="2">MI</th> <th rowspan="2">LAST (IF NOT SAME AS EMPLOYEE)</th> <th rowspan="2">LANGUAGE CODE</th> <th colspan="3">DATE OF BIRTH</th> <th colspan="2">SEX</th> <th rowspan="2">RELATION CODE</th> <th colspan="2">SOCIAL SECURITY NUMBER</th> </tr> <tr> <th>MO</th> <th>DAY</th> <th>YR</th> <th>M</th> <th>F</th> <th>-</th> <th>-</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>EMPLOYEE</td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>M</td> <td>F</td> <td>01</td> <td>-</td> <td>-</td> </tr> <tr> <td>02</td> <td>SPOUSE</td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>M</td> <td>F</td> <td></td> <td>-</td> <td>-</td> </tr> <tr> <td>03</td> <td>DEPENDENT</td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>M</td> <td>F</td> <td></td> <td>-</td> <td>-</td> </tr> <tr> <td>04</td> <td>DEPENDENT</td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>M</td> <td>F</td> <td></td> <td>-</td> <td>-</td> </tr> <tr> <td>05</td> <td>DEPENDENT</td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>M</td> <td>F</td> <td></td> <td>-</td> <td>-</td> </tr> <tr> <td>06</td> <td>DEPENDENT</td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>M</td> <td>F</td> <td></td> <td>-</td> <td>-</td> </tr> </tbody> </table>											RELATION CODE	FIRST	MI	LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH			SEX		RELATION CODE	SOCIAL SECURITY NUMBER		MO	DAY	YR	M	F	-	-	01	EMPLOYEE					-	-		M	F	01	-	-	02	SPOUSE					-	-		M	F		-	-	03	DEPENDENT					-	-		M	F		-	-	04	DEPENDENT					-	-		M	F		-	-	05	DEPENDENT					-	-		M	F		-	-	06	DEPENDENT					-	-		M	F		-	-
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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	CA	CV	EN	FR	HA	HM	IT	KH	LO	MN	PT	RU	SP	VI	OTHER	Specify _____
	American Sign Language	Cantonese	Cape Verdean	English	French	Haitian	Hmong	Italian	Khmer	Laotian	Mandarin	Portuguese	Russian	Spanish	Vietnamese		

<p>* IF YOU HAVE LISTED A FULL-TIME STUDENT(S) OVER AGE 19 BUT UNDER THE MAXIMUM STUDENT AGE, SUPPLY THE FOLLOWING INFORMATION:</p> <p>STUDENT(S) NAME _____ NAME OF SCHOOL(S) _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="text-align: center; color: red;">THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY</p>	<p>HAVE YOU EVER BEEN A MEMBER OF <i>Pilgrim Health Care</i>, Harvard Community Health Plan, HCHP OF NE, HPHC OR HPHC OF NE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.</p> <p>E-MAIL ADDRESS: _____ (OPTIONAL)</p> <p style="text-align: center; color: red;">YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.</p>
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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, 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