Harvard Pilgrim Health Care

REASONS FOR SUBMISSION (PLEASE CHECK ONE)	**QUALIFYING EVENT DATE:**________________
☐NEW ENROLLMENT/CONTRACT ☐CHANGE TO CONTRACT ☐TERMINATE CONTRACT	☐ OPEN ENROLLMENT ☐NEW HIRE ☐COBRA ☐LOSS OF INSURANCE ☐COURT ORDER ☐BIRTH/ADOPTION ☐P/T TO F/T ☐MARRIAGE/DIVORCE ☐MOVED IN/OUT OF SERVICE AREA ☐DEATH ☐VOLUNTARY CANCELLATION

REASON FOR CHANGES (CHECK ALL THAT APPLY)

☐CHANGE COVERAGE TYPE ☐ADD DEPENDENT LISTED ☐TERMINATE DEPENDENT LISTED ☐TRANSFER/RE-ENROLL TO COBRA

☐OTHER:____

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	*GROUP #DIVISION*	*DATE OF HIRE*	*EFFECTIVE DATE OF COVERAGE*

SUBSCRIBER INFORMATION

HP ID	*PRODUCT:* ☐HMO ☐PPO ☐POS ☐ACCESS AMERICA	*PLAN NAME*

SUBSCRIBER FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F

SSN	*HOME PHONE*	*WORK PHONE*	*CELL PHONE*	*EMAIL*

STREET ADDRESS (NO PO BOX)	*APT #*	*CITY*	*STATE*	*ZIP*

PRIMARY LANGUAGE (OPTIONAL)	*PCP FULL NAME*	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID #*

SPOUSE INFORMATION

SPOUSE FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F

SSN	*MAILING ADDRESS (IF DIFFERENT)*	*RELATION CODE*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID #*

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID#*

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID#*

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID#*

☐PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? ☐YES. PLEASE COMPLETE ☐NO

NAME OF HEALTH PLAN	*HEALTH PLAN ID NUMBER*	*EFFECTIVE DATE*	*NAMES OF SUBSCRIBER*

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINSTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, IMCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPLANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

___________________________ __________ ___________________________ __________

EMPLOYEE SIGNATURE *DATE* *EMPLOYER SIGNATURE* *DATE*

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	Contract change	Termination
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. ***IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.***
- **Primary Care Provider:** If your plan is an HMO or POS, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
  - 02 Spouse/Civil Union
  - 03 Child up to age 26
  - 06 Disabled (verification required)
  - 07 Ex-spouse
  - DP Domestic Partner
  - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.