

- REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)**
- ENROLLMENT
  - CHANGE
  - TERMINATION
  - NEW HIRE
  - COBRA
  - CHANGE COVERAGE TYPE
  - LEFT EMPLOYMENT
  - NO LONGER ELIGIBLE
  - ANNUAL OPEN ENROLLMENT
  - ADD DEPENDENT LISTED BELOW
  - LOSS OF INSURANCE DATE (ATTACH DOCUMENTS)
  - TERMINATE DEPENDENT LISTED BELOW
  - MARRIAGE DATE
  - MOVED FROM SERVICE AREA
  - DECEASED DATE
  - PTD TO FTR DATE
  - MEMBER DATE

TO BE COMPLETED BY HPHC ONLY. GROUP / COMPANY NAME: \_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ TYPE OF COVERAGE:  INDIVIDUAL  2-PERSON (ONLY WHERE OFFERED)  FAMILY  OTHER \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FIRST MIDDLE LAST \_\_\_\_\_

CITY: \_\_\_\_\_ STREET: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_ PO BOX: \_\_\_\_\_

TELEPHONE (HOME): \_\_\_\_\_ TELEPHONE (WORK): \_\_\_\_\_

FIRST MI LAST (IF NOT SAME AS EMPLOYEE) LANGUAGE MO DATE OF BIRTH 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 SPOUSE DEPENDENT DEPENDENT DEPENDENT DEPENDENT

LANGUAGE CODE AFTER EACH MEMBER'S NAME THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS

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: \_\_\_\_\_

IF YOU HAVE LISTED A FULL-TIME STUDENT(S) AGE 19 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION: NAME OF SCHOOL(S) STATE

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)

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. MAIN MEMBERS: PLEASE NOTE THAT THE SUBROGATION PROVISION APPLICABLE TO MAIN MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS. NEW HARBINGER 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:81(V)(b)). 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 DEFFRAUDING 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: \_\_\_\_\_