The Harvard Pilgrim PPO

HPHC Insurance Company, Inc.

PO BOX 9185 QUINCY, MA 02269
1-800-637-4751
www.harvardpilgrim.org

NOTE: *FOR CT PPO ENROLLMENTS ONLY*

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
			—	

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	CA	CV	EN	FR	HA	HM	IT	KH	LO	MN	PT	RU	SP	VI	OTHER ☐
American Sign Language	Cantonese	Cape Verdean	English	French	Haitian	Hmong	Italian	Khmer	Laotian	Mandarin	Portuguese	Russian	Spanish	Vietnamese	Specify

ARE YOU CURRENTLY A MEMBER OF ANOTHER MEDICAL INSURANCE PLAN?

IF YES, PLEASE LIST OTHER MEDICAL PLAN(S) ON THE LINES BELOW.

_____

_____

_____

HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, HPHC OF CT, 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 HPHC MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HPHC IN YOUR ENROLLMENT KIT.

PLEASE NOTE THAT AN ENROLLED PARTICIPANT SHALL BE ALLOWED A GRACE PERIOD OF TEN (10) DAYS FOR MAKING ANY PAYMENT DUE UNDER CONTRACT.

I UNDERSTAND THAT A COPY OF THIS FORM IS PROVIDED TO ME AS PART OF MY HARVARD PILGRIM PPO PLAN AND IS INCORPORATED THEREIN BY REFERENCE.

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