Harvard Pilgrim Health Care

REASONS FOR SUBMISSION (PLEASE CHECK ONE)

☐NEW ENROLLMENT/CONTRACT

☐CHANGE TO CONTRACT

☐TERMINATE CONTRACT

QUALIFYING EVENT DATE:______________

☐ 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