



Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

93 Worcester St., Ste 100,  
Wellesley, MA 02481  
(800) 848-9995  
Fax: (617) 509-2515

427 Main St., Ste 200,  
Worcester, MA 01608  
(800) 848-9995  
Fax: (508) 792-7191

650 Elm St., 7<sup>th</sup> Fl,  
Manchester, NH 03101  
(800) 544-9759  
Fax: (603) 656-9560

1 Market St., 3<sup>rd</sup> Fl,  
Portland, ME, 04101  
(888) 476-2463  
Fax: (207) 761-0194

City Place II, 185 Asylum St., 2<sup>nd</sup> Fl,  
Hartford, CT 06103  
(877) 594-7190  
Fax: (860) 757-6901

### Group Information Form

**Company Name:** \_\_\_\_\_

Other "DBA" or Alias Names: \_\_\_\_\_

Does company regularly employ at least one individual that is not also the owner or owner's spouse?  YES  NO

**Company Location:**

Street No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**Billing Location** (If different from above):

Street No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**Does your company have any physical office locations outside the state in which this HPHC policy is underwritten?**

No  Yes-Please list street address, city, state and zip code for all locations. Additional space is available on second page.

**Contact Information:**

Contact type	Name	Phone number	Email
Executive	_____	_____	_____
Benefits Administrator	_____	_____	_____
Billing	_____	_____	_____
HPHConnect	_____	_____	_____
Employer Mailing	_____	_____	_____
Broker*	_____	_____	_____

\*Please complete and submit the *Identification of Third-Party Representatives* form.

**Company Information:**

Anniversary Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Tax ID \_\_\_\_\_

SIC Code \_\_\_\_\_ Industry \_\_\_\_\_

Total Employees \_\_\_\_\_ Part-time \_\_\_\_\_ Full-time \_\_\_\_\_

Total Full Time Equivalents \_\_\_\_\_

Total Eligible Employees \_\_\_\_\_ Part-time \_\_\_\_\_ Full-time \_\_\_\_\_

COBRA \_\_\_\_\_ Retirees over 65 \_\_\_\_\_ Retirees under 65 \_\_\_\_\_ Working Aged \_\_\_\_\_

Company Contribution (not required for any small groups sold in NH or ME)

New Hire Waiting Period (may not exceed 90 days)

Part Time Eligibility  Not eligible  Eligible—Definition: \_\_\_\_\_ minimum hours/week

Dependent Age (if greater than 26)

Domestic Partner  Not covered  Same & Opposite Sex  Opposite Sex Only  Same Sex Only

The foregoing statements are (1) true and correct to the best of my knowledge and belief and (2) made to induce the issuance of health coverage. In Maine, 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.



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Group Information Form

Dental Information: (required for MA and ME small groups purchasing medical plans without dental)

Name of Dental Carrier\* \_\_\_\_\_ Name of Dental Plan\* \_\_\_\_\_

\*Dental Carrier and Plan must be considered ACA Compliant by State in order for medical plan to be sold without dental rider.

HRA &/or HSA Account Information: (if applicable) Additional documentation may be required

[ ] HRA HRA Vendor Name: \_\_\_\_\_

Corresponding HPHC Plan(s): \_\_\_\_\_

HRA Funding Amount (\$ or %) Individual: Family Other:

[ ] HSA HSA Vendor Name: \_\_\_\_\_

Corresponding HPHC Plan(s): \_\_\_\_\_

HSA Funding Amount (\$ or %) Individual: Family Other:

HPHC Selected Plans:

Plan #1 Type: [ ] HMO [ ] PPO [ ] POS [ ] Other: \_\_\_\_\_

Plan #1 Name or ID #: \_\_\_\_\_

Plan #1 Quoted Rates: Individual-\$ Dual-\$ Family-\$ Other-\$

Plan #2 Type: [ ] HMO [ ] PPO [ ] POS [ ] Other: \_\_\_\_\_

Plan #2 Name or ID #: \_\_\_\_\_

Plan #2 Quoted Rates: Individual-\$ Dual-\$ Family-\$ Other-\$

Prior Insurer Plan Information:

Prior Insurer Name: \_\_\_\_\_

Funding Arrangement: \_\_\_\_\_

Plan #1 Type: [ ] HMO [ ] PPO [ ] POS [ ] Other: \_\_\_\_\_

Plan #1 Description: \_\_\_\_\_

Plan #1 Rates: Individual-\$ Dual-\$ Family-\$ Other-\$

Plan #2 Type: [ ] HMO [ ] PPO [ ] POS [ ] Other: \_\_\_\_\_

Plan #2 Description: \_\_\_\_\_

Plan #2 Rates: Individual-\$ Dual-\$ Family-\$ Other-\$

Additional Information:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

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