Harvard Pilgrim Buy Direct

1-888-333-HPHC
www.harvardpilgrim.org

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

☐ **ENROLLMENT** ☐ **CHANGE**
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW
- ☐ NAME/ADDRESS CHANGE
- ☐ MARRIAGE DATE _____
- ☐ NEWBORN DATE _____

☐ **TERMINATION**
- ☐ NO LONGER ELIGIBLE
- ☐ DECEASED DATE _____

TO BE COMPLETED BY HPHC		
ES	BS	US

TO BE COMPLETED BY HPHC	COVERAGE TYPE	INCLUDE DRUG COVERAGE	PLAN SELECTED	GROUP #/DIVISION - TO BE COMPLETED BY HPHC	REQUESTED EFFECTIVE DATE
H P	☐ HMO ☐ PPO	☐ DRUG ☐ NO DRUG			

APPLICANT NAME (OLDEST ADULT MUST BE LISTED AS APPLICANT)

FIRST **MIDDLE** **LAST**

ADDRESS

APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

TYPE OF COVERAGE
☐ INDIVIDUAL ☐ INDIVIDUAL & CHILD(REN)
☐ INDIVIDUAL & SPOUSE ☐ FAMILY

MONTHLY AMOUNT DUE
$

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE DP DOMESTIC PARTNER SP SPOUSAL EQUIVALENT 03 CHILD UNDER 19 03 CHILD TAX DEPENDENT 19-25
03 CHILD 19-25 TAX DEP/2 YR EXTN 03 FULL-TIME STUDENT 19 AND OVER 04 STEPCHILD UNDER 19
06 HANDICAPPED (VERIFICATION REQUIRED) 07 EX-SPOUSE

IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN.
AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.

FIRST MI LAST (IF NOT SAME AS APPLICANT)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER (NOT APPLICABLE FOR **PPO**)	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?		PCP# NOT APPLICABLE FOR **PPO**
APPLICANT		- -	M F	01	- -		Y	N	
SPOUSE		- -	M F		- -		Y	N	
DEPENDENT		- -	M F		- -		Y	N	
DEPENDENT		- -	M F		- -		Y	N	
DEPENDENT		- -	M F		- -		Y	N	
DEPENDENT		- -	M F		- -		Y	N	

LANGUAGE CODES (OPTIONAL)

WHAT LANGUAGE DO YOUI SPEAK MOST OFTEN? PLEASE LIST THE APP0PRIATE 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 ☐ _____ Specify

HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, 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.**

THE INFORMATION SUPPLIED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT MEMBERSHIP WILL BECOME EFFECTIVE WHEN ACCEPTED BY THE PLAN. I UNDERSTAND THAT MY COVERED BENEFITS UNDER THIS PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT, WHICH MAY BE REVISED FROM TIME TO TIME. DURING MY MEMBERSHIP I AUTHORIZE ANY HEALTH CARE PROVIDER OR OTHER HEALTH PLAN TO PROVIDE MEDICAL INFORMATION AND RECORDS TO THE PLAN OR PLAN AFFILIATED HEALTH CARE PROVIDERS. I ALSO AUTHORIZE THE PLAN AND ANY HEALTH CARE PROVIDER RENDERING SERVICES TO ME OR MY DEPENDENTS TO RECEIVE COPIES OF MY OR MY DEPENDENTS' MEDICAL RECORDS. I UNDERSTAND THAT ANY INFORMATION OBTAINED UNDER THIS AUTHORIZATION WILL BE USED IN THE DELIVERY OF HEALTH SERVICES, TO DETERMINE ELIGIBILITY AND ENTITLEMENT TO BENEFITS (INCLUDING REIMBURSEMENT BY THIRD PARTIES), IN EDUCATION AND RESEARCH IN ACCORDANCE WITH GOVERNMENT REGULATIONS, AND IN CONNECTION WITH THE PLAN'S PROFESSIONAL AND UTILIZATION REVIEW ACTIVITIES. PERMISSION IS NOT GIVEN FOR ANY REDISCLOSURE OF THIS INFORMATION OTHER THAN AS SPECIFIED ABOVE. I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR TO MY AUTHORIZED REPRESENTATIVE, UPON REQUEST. FINAL PREMIUM RATES WILL BE BASED ON PLAN'S RECEIPT OF A COMPLETED ENROLLMENT APPLICATION, WHICH INCLUDES THIS APPLICATION AND THE FIRST MONTH'S PREMIUM. WE RESERVE THE RIGHT TO WITHDRAW OR RECALCULATE RATES THAT WERE BASED ON INCOMPLETE OR INACCURATE INFORMATION. A COMPLETE AND ACCURATE ENROLLMENT APPLICATION MUST BE RECEIVED BY HPHC AT LEAST FIVE (5) DAYS BEFORE THE FIRST DAY OF THE MONTH FOR WHICH YOU REQUEST COVERAGE. IF PLAN RECEIVES YOUR COMPLETE ENROLLMENT APPLICATION AFTER THIS DATE, YOUR COVERAGE WILL BE RE-RATED AND WILL BEGIN THE FOLLOWING MONTH. YOU UNDERSTAND THAT THE SUBROGATION PROVISION, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS.

COVERAGE UNDERWRITTEN OR ADMINISTERED BY HARVARD PILGRIM HEALTH CARE, INC. OR ITS AFFILIATE, HPHC INSURANCE COMPANY HEALH CARE, INC.

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 APPLICANT MUST SIGN AND DATE THIS FORM FOR ENROLLMENT. IF THE APPLICANT IS A CHILD UNDER AGE 19, THIS FORM MUST INSTEAD BE SIGNED BY A PARENT OR LEGAL GUARDIAN.

APPLICANT SIGNATURE _____ DATE _____ APPLICANT'S PARENT/LEGAL GUARDIAN (If applicable) _____ DATE _____