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

93 Worcester St., Suite 100, Wellesley, MA 02481	(800) 848-9995	Fax: (617) 509-2515
427 Main St., Suite 200, Worcester, MA 01608	(800) 848-9995	(508) 792-7191
160 South River Rd., Suite 201, Bedford, NH 03110	(800) 544-9759	(603) 656-9560
1 Market Street, 3rd floor, Portland, ME, 04101	(888) 476-2463	(207) 761-0194

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 Fax

Billing Location (If different from above):

Street No.

City State Zip

Phone Fax

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 small groups purchasing medical plans without dental)

Name of Dental Carrier _____ Name of Dental Plan _____

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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