



PO BOX 4090 - CONCORD, NH 03302
 (888) 960-6448 (P) (800) 229-6902 (F)

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

ENROLLMENT

- NEW HIRE
- ANNUAL OPEN ENROLLMENT
- PART TIME TO FULL TIME: _____
- LOSS OF INSURANCE DATE: _____
(ATTACH DOCUMENTS)

CHANGE

- CHANGE COVERAGE TYPE
- ADD DEPENDENT LISTED BELOW
- TERMINATE DEPENDENT LISTED BELOW
- NAME CHANGE - PREVIOUS NAME: _____
- MARRIAGE DATE: _____
- NEWBORN DATE: _____

TERMINATION

- VOLUNTARY CANCELLATION (SIGNATURE REQUIRED)
- DECEASED DATE: _____
- TRANSFER FROM GROUP #:** _____

DECLINING COVERAGE

TO BE COMPLETED BY EMPLOYER:

EMPLOYER GROUP NAME	NAMING CONVENTION/GROUP NUMBER	DATE OF HIRE	EFFECTIVE DATE

TO BE COMPLETED BY EMPLOYEE:

SUBSCRIBER INFORMATION					PLAN TYPE				
FIRST MIDDLE LAST					<input type="checkbox"/> HMO: _____ <input type="checkbox"/> HMO-LP <input type="checkbox"/> EH/EHO: _____ <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> ME <input type="checkbox"/> ME + PDP				
MAILING ADDRESS					COVERAGE TYPE				
STREET / PO BOX					<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> TWO-PERSON <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER (ONLY WHERE OFFERED)				
CITY STATE ZIP () TELEPHONE					PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK 02 – SPOUSE/CIVIL UNION 03 – CHILD UNDER 26 04 – DISABLED DEPENDENT (VERIFICATION REQUIRED) CHILD DEPENDENTS ARE ELIGIBLE FOR COVERAGE THROUGH THE MONTH THAT THEY TURN 26 AS AN HMO OR POS PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP) UPON ENROLLMENT IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.				
EMAIL ADDRESS									
FIRST	MIDDLE	LAST (IF NOT SAME AS EMPLOYEE)	DATE OF BIRTH MO / DAY / YR	SEX (PLEASE CIRCLE)	RELATION CODE	SOCIAL SECURITY NUMBER	PRIMARY CARE PHYSICIAN NAME AND TOWN FOR EACH MEMBER	HARVARD PILGRIM PCP # (HMO AND POS PLANS ONLY)	CURRENT PATIENT OF THIS DOCTOR?
EMPLOYEE			/ /	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

MEDICARE ENHANCE SUBSCRIBERS MUST PROVIDE A COPY OF THEIR MEDICARE PART A AND B CARD UPON ENROLLMENT.

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 HARVARD PILGRIM MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HARVARD PILGRIM IN YOUR ENROLLMENT KIT. I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

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.

BY SIGNING BELOW, I CONSENT TO THE USE OF EMAIL COMMUNICATION BETWEEN MYSELF, THE NEW HAMPSHIRE INTERLOCAL TRUST, HARVARD PILGRIM AND OTHER PROGRAM VENDORS. I CAN OPT-OUT OF THESE COMMUNICATIONS AT ANYTIME.

THE EMPLOYEE AND THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

EMPLOYEE SIGNATURE

DATE

EMPLOYER SIGNATURE

DATE