



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:**

<b>SUBSCRIBER INFORMATION</b>				<b>PLAN TYPE</b>						
				<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						
<b>MAILING ADDRESS</b>				<b>COVERAGE TYPE</b>						
FIRST MIDDLE LAST STREET / PO BOX TELEPHONE CITY STATE ZIP ( )				<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> TWO-PERSON <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER (ONLY WHERE OFFERED)						
				<b>PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK</b> 02 – SPOUSE    03 – CHILD UNDER 26    04 – DISABLED DEPENDENT (VERIFICATION REQUIRED) <b>CHILD DEPENDENTS ARE ELIGIBLE FOR COVERAGE THROUGH THE MONTH THAT THEY TURN 26</b> <b>AS AN HMO OR POS PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP) UPON ENROLLMENT</b> <b>IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.</b>						
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.

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS. \_\_\_\_\_

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

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
EMPLOYER SIGNATURE

\_\_\_\_\_  
DATE

MEMBERS ARE ENCOURAGED TO OBTAIN THEIR PCP'S NUMBER BY VISITING HARVARD PILGRIM'S ONLINE PROVIDER DIRECTORY AT [www.harvardpilgrim.org](http://www.harvardpilgrim.org)

**SEND COMPLETED AND SIGNED FORMS TO YOUR EMPLOYER**