HPHC Insurance Company
The PPO Plan

PO BOX 9185 • QUINCY, MA 02269
1-888-333-HPHC
www.harvardpilgrim.org

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

☐ ENROLLMENT
- ☐ NEW HIRE
- ☐ COBRA
- ☐ ANNUAL OPEN ENROLLMENT
- ☐ LOSS OF INSURANCE DATE ________ (ATTACH DOCUMENTS)
- ☐ P/T TO F/T DATE ________

☐ CHANGE
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW
- ☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE DATE ________ (ATTACH DOCUMENTS
- ☐ MARRIAGE DATE ________
- ☐ NEWBORN DATE ________

☐ TERMINATION
- ☐ LEFT EMPLOYMENT
- ☐ VOLUNTARY CANCELLATION
- ☐ MOVED FROM SERVICE AREA
- ☐ NO LONGER ELIGIBLE
- ☐ DECEASED DATE ________

TO BE COMPLETED BY HPHC ONLY.	GROUP / COMPANY NAME	DATE OF HIRE	GROUP #/DIVISION	EFFECTIVE DATE
H P P			—	

EMPLOYEE NAME
FIRST **MIDDLE** **LAST**

ADDRESS
APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( ) TELEPHONE (WORK) ( )

TYPE OF COVERAGE
- ☐ INDIVIDUAL
- ☐ 2-PERSON (ONLY WHERE OFFERED)
- ☐ FAMILY
- ☐ OTHER ________

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE 03 CHILD UNDER 19 03 CHILD TAX DEPENDENT 19-25 (MA ONLY) 03 CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY)
04 STEPCHILD UNDER 19 05* FULL-TIME STUDENT 19 AND OVER 06 HANDICAPPED (VERIFICATION REQUIRED) 07 EX-SPOUSE

FIRST MI LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH MO - DAY - YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER
EMPLOYEE		- -	M F	01	- -
SPOUSE		- -	M F		- -
DEPENDENT		- -	M F		- -
DEPENDENT		- -	M F		- -
DEPENDENT		- -	M F		- -
DEPENDENT		- -	M F		- -

LANGUAGE CODES (OPTIONAL)

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS	CA	CV	EN	FR	HA	HM	IT	KH	LO	MN	PT	RU	SP	VI	OTHER
American Sign Language	Cantonese	Cape Verdean	English	French	Haitian	Hmong	Italian	Khmer	Laotian	Mandarin	Portuguese	Russian	Spanish	Vietnamese	Specify

*** IF YOU HAVE LISTED A FULL-TIME STUDENT(S) AGE 19 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION:**

STUDENT(S) NAME **NAME OF SCHOOL(S)** **STATE**

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY

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.

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 HPHC INSURANCE COMPANY MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HPHC INSURANCE COMPANY IN YOUR ENROLLMENT KIT.
MAINE MEMBERS: PLEASE NOTE THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS.
NEW HAMPSHIRE MEMBERS: PLEASE NOTE THAN AN ENROLLED PARTICIPANT SHALL BE ALLOWED A GRACE PERIOD OF TEN (10) DAYS FOR MAKING ANY PAYMENT DUE UNDER CONTRACT (N.H. RSA 420-B:8(IV)(b).
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.

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

EMPLOYEE SIGNATURE ________ DATE ________ EMPLOYER SIGNATURE ________ DATE ________