

# The Harvard Pilgrim HMO

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West Suburban Health Group/Town of Needham Plan Type:

- Benchmark  
 Qualified High Deductible Health Plan

**REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)**

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|--|--|--|
| <input type="checkbox"/> <b>ENROLLMENT</b>                               | <input type="checkbox"/> <b>CHANGE</b>                                   | <input type="checkbox"/> <b>TERMINATION</b>      |
| <input type="checkbox"/> NEW HIRE  | <input type="checkbox"/> CHANGE COVERAGE TYPE                            | <input type="checkbox"/> LEFT EMPLOYMENT         |
| <input type="checkbox"/> ANNUAL OPEN ENROLLMENT                          | <input type="checkbox"/> ADD DEPENDENT LISTED BELOW                      | <input type="checkbox"/> NO LONGER ELIGIBLE      |
| <input type="checkbox"/> LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS) | <input type="checkbox"/> TERMINATE DEPENDENT LISTED BELOW                | <input type="checkbox"/> VOLUNTARY CANCELLATION  |
| <input type="checkbox"/> P/T TO F/T DATE _____                           | <input type="checkbox"/> NAME/ADDRESS CHANGE                             | <input type="checkbox"/> DECEASED DATE _____     |
|  | <input type="checkbox"/> LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS) | <input type="checkbox"/> MOVED FROM SERVICE AREA |
|  | <input type="checkbox"/> MARRIAGE DATE _____                             |  |
|  | <input type="checkbox"/> NEWBORN DATE _____                              |  |

<b>TO BE COMPLETED BY HPHC ONLY.</b>		GROUP / COMPANY NAME	DATE OF HIRE	GROUP #/DIVISION	EFFECTIVE DATE
H   P		West Suburban Health Group/Town of Needham			
EMPLOYEE NAME			TYPE OF COVERAGE		
FIRST MIDDLE LAST			<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 2-PERSON (ONLY WHERE OFFERED)		
HOME ADDRESS			<input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER		
APT. NO. STREET PO BOX			<b>PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK</b>		
CITY STATE ZIP COUNTY			<b>02—SPOUSE/CIV UN 03—CHILD UNDER 19, CHILD TAX DEP 19-25 (MA ONLY), CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY), CHILD UP TO 26 (NH ONLY) 04—STEPCHILD UNDER 19 05*—FULL-TIME STUDENT 19 AND OVER 06—HANDICAPPED (VERIF REQ 07—EX-SPOUSE</b>		
TELEPHONE (HOME)		TELEPHONE (WORK)		<b>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.</b>	
( )		( )			

FIRST MI LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?		PCP#
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	

<b>LANGUAGE CODES (OPTIONAL)</b>	<b>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.</b>														
	<input type="checkbox"/> AS American Sign Language	<input type="checkbox"/> CA Cantonese	<input type="checkbox"/> CV Cape Verdean	<input type="checkbox"/> EN English	<input type="checkbox"/> FR French	<input type="checkbox"/> HA Haitian	<input type="checkbox"/> HM Hmong	<input type="checkbox"/> IT Italian	<input type="checkbox"/> KH Khmer	<input type="checkbox"/> LO Laotian	<input type="checkbox"/> MN Mandarin	<input type="checkbox"/> PT Portuguese	<input type="checkbox"/> RU Russian	<input type="checkbox"/> SP Spanish	<input type="checkbox"/> VI Vietnamese

<p>* IF YOU HAVE LISTED A FULL-TIME STUDENT(S) AGE 19 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION:</p> <p>STUDENT(S) NAME _____ NAME OF SCHOOL(S) _____ STATE _____</p> <p>_____</p> <p>_____</p> <p style="text-align: center;">THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY</p>	<p>HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.</p> <p>E-MAIL ADDRESS: _____ (OPTIONAL)</p> <p style="text-align: center;">YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.</p>
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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.  
 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.  
 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
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