HPHC Insurance Company
The PPO Plan

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

REASON FOR SUBMISSION (Please check all that apply)

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

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

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

CONTRACT / ID NUMBER: H | P | P | | | | | | |

GROUP / COMPANY NAME

DATE OF HIRE

DIVISION

EFFECTIVE DATE

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

ADDRESS
APT. NO. STREET PO BOX

COUNTY

CITY STATE ZIP

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 UNMARRIED CHILD UNDER 19
- 04 UNMARRIED STEPCHILD UNDER 19
- 05* UNMARRIED FULL-TIME STUDENT OVER AGE 19
- 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
01	EMPLOYEE		- -	M	F	01	- -
02	SPOUSE		- -	M	F		- -
03	DEPENDENT		- -	M	F		- -
04	DEPENDENT		- -	M	F		- -
05	DEPENDENT		- -	M	F		- -
06	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) OVER AGE 19 BUT UNDER THE MAXIMUM STUDENT AGE,** SUPPLY THE FOLLOWING INFORMATION:

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

____

____

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THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY

HAVE YOU EVER BEEN A MEMBER OF *Pilgrim Health Care,* Harvard Community Health Plan, HCHP OF NE, HPHC OR HPHC OF NE? ☐ 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 THE EVIDENCE OF COVERAGE. I UNDERSTAND THAT BY SIGNING BELOW I AM AGREEING TO THE TERMS OF THE EVIDENCE OF COVERAGE. 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.
I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME , OR MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.
NEW HAMPSHIRE MEMBERS: BY SIGNING BELOW I ATTEST THAT ANY HEALTH INFORMATION PROVIDED AS PART OF MY APPLICATION TO THE PLAN BY ME OR ON MY BEHALF IS COMPLETE AND ACCURATE. PLEASE NOTE THAT 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).

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, SPOUSE AND ALL DEPENDENTS AGE 18 YEARS AND OVER MUST SIGN THIS FORM FOR ENROLLMENT.

EMPLOYEE SIGNATURE	DATE	DEPENDENT SIGNATURE (age 18 years - over)	DATE	DEPENDENT SIGNATURE (age 18 years - over)	DATE
SPOUSE SIGNATURE (if applicable)	DATE	DEPENDENT SIGNATURE (age 18 years - over)	DATE	EMPLOYER SIGNATURE	DATE