NEW HAMPSHIRE INTERLOCAL TRUST

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

FIRST MIDDLE LAST

MAILING ADDRESS

STREET / PO BOX

CITY STATE ZIP TELEPHONE ( )

PLAN TYPE

☑ HMO: _____ ☐ HMO-LP ☐ ELEVATEHEALTH ☐ POS ☐ PPO ☐ ME ☐ ME + PDP

COVERAGE TYPE

☐ INDIVIDUAL ☐ TWO-PERSON ☐ FAMILY ☐ OTHER (ONLY WHERE OFFERED)

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 – SPOUSE **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.

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

SEND COMPLETED AND SIGNED FORMS TO YOUR EMPLOYER