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: _____

☐ **TI**
- ☐
- ☐
- ☐ **TI**
- ☐ **DE**

TO BE COMPLETED BY EMPLOYER:

EMPLOYER GROUP NAME	NAMING CONVENTION/GROUP NUMBER	DATE OF HIRE

TO BE COMPLETED BY EMPLOYEE:

SUBSCRIBER INFORMATION

FIRST MIDDLE LAST

MAILING ADDRESS

STREET / PO BOX

CITY STATE ZIP TELEPHONE ( )

EMAIL ADDRESS

PLAN TYPE
☐ **HMO:** _____ ☐ **HMO-LP** ☐ **EH/EHO:** _____ ☐ **POS**

COVERAGE TYPE
☐ **INDIVIDUAL** ☐ **TWO-PERSON** ☐ **FAMILY** ☐ **OTHE**

PLEASE USE THE CODES LISTED BELOW TO COMPLETE D

02 – SPOUSE/CIVIL UNION **03** – CHILD UNDER 26 **04** –

CHILD DEPENDENTS ARE ELIGIBLE FOR COVERAGE THI

AS AN HMO OR POS PLAN MEMBER YOU MUST CHOOSE A PRI
IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MO

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 MEME
EMPLOYEE		M	F	01	- -	
SPOUSE		M	F		- -	
DEPENDENT		M	F		- -	
DEPENDENT		M	F		- -	
DEPENDENT		M	F		- -	
DEPENDENT		M	F		- -	

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 YOU 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.

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 DE

BY SIGNING BELOW, I CONSENT TO THE USE OF EMAIL COMMUNICATION BETWEEN MYSELF, THE NEW HAMPSHIRE INTERLOCAL TRUST, HARVARD PILGRIM AND OTHER PROGRAM VENDORS. I CAN OPT-OU

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

EMPLOYEE SIGNATURE **DATE** **EMPLOYER SIGNATURE**

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