

Harvard Pilgrim Individual

harvardpilgrim.org

a Point32Health company	Reason for Submission: (Check all that apply)		ı: 🗆	□ Open Enrollmen □ New □ Change			The state of the					
To be completed by HPHC if new Plan Selected							Check applicable option:			Broker NPN		
H P							☐ ICHRA☐ QSEHRA (choose from the following): Eligible employee: Type of Reimbursement:					
Applicant Name											Broker Name	
First Middle		Last				☐ Sul	scriber only	Plan premiums only				
Address Apt. No. Street			PO	РО Вох			☐ Spouse only ☐ Plans Premiums and ☐ Subscriber and Spouse ☐ Medical/Pharmacy			HPHC Vendor ID		
,			County			claim reimbursement Not Applicable			ent -	Requested Effective Date		
Telephone (Home) () Telephone (Mobile/Cell) ()					member you	must choos	e a primary care physic	member select a primary care physician. imary care physician (PCP). If you do not have a PCP, st specialty care may not be covered. Monthly Amount Due \$			mount Due	
First MI Last (if not the same as applica	st MI Last (if not the same as applicant) Tobacco Use Month D.		th Year			ecurity Select a primary of		are physician and town for Are y		a regular patient his doctor?	t PCP# not applicable for PPC	
Applicant	Y N			M F	-	-			Y	N		
Spouse	YN			M F	-	-			Y	N		
Dependent	YN			M F	-	-			Y	N		
Dependent	YN			M F	-	-			Y	N		
Dependent	YN			M F	-	-			Y	N		
Dependent	YN			M F	-	-			Y	N		
Dependent	YN			M F	-	-			Y	N		
Tobacco Use (NH only) Circle "Y" for each individua Circle "N" for each individua	l, 18 years or o	older, who within the older, who within the	e last six e last six	months h a	as used any as <i>not</i> used	tobacco pro any tobacco	oduct four or more tile o product four or mo	mes per week on average (e re times per week on avera	excluding ge (exclud	religious or c ding religious	eremonial uses). or ceremonial uses)	
If you would like to receive a menu of elec	tronic ways t	o interact with us,	list you	r e-mail ac	ddress here.	E-ma	il address:				(optional	
The information supplied on this application my covered benefits under this plan will be to provide medical information and records copies of my or my dependent's medical re to benefits (including reimbursement by the Permission is not given for any redisclosur request. Final premium rates will be based requested eligibility documentation before residents, I understand that if the plan that Hampshire health marketplace (exchange)	explained in a s to the plan o cords. I under iird parties), ir e of this inforr on plan's rece coverage is e I am purchasi You understa	a separate documer or plan affiliated hea stand that any infor n education and rese nation other than a ipt of a completed e affectuated. The hea ing from Harvard Pi and that the Subrogand	nt, which Ith care rmation earch in s specifenrollmo lith plar Igrim or ation pr	h may be reproviders to obtained accordance above. The application is affiliated affiliated affiliated affiliated accordance are applications affiliated accordance affiliated accordance affiliated accordance and accordance accordan	revised from . I also authounder this a ce with gove I understan ation which i the right to ses does not utlined in a se	time to tin orize the pla uthorizatio ernment red d that a col includes the withdraw of include per separate do	ne. During my memlan and any health ca an and any health ca n will be used in the gulations, and in con by of this application s application and th r recalculate rates the diatric dental covera cument, permits Su	pership I authorize any hea re provider rendering servi delivery of health services in with the plan's pro n will be given to me, or my e required binder payment nat were based on incompl ge a certified pediatric den brogation payments on a j	Ith care p ces to me , to deter ofessional authoriz . Harvard ete or ina ital plan is ust and e	rovider or ot e or my depe rmine eligibie I and utilizati ted represent I Pilgrim mus accurate infor s available or quitable basi	ther health plan endents to receive lity and entitlement ion review activities. tative, upon st approve any rmation. For NH n or off the New is.	
Coverage underwritten or It is a crime to knowingly provide false, in		, ,										
a denial of insurance benefits.	<u> </u>						· ·	t instead be signed by a p				
A marilian at Co	A		F.:		_	A 1*	contin Deventill	andian (if and in-1912)	_			
Applicant Signature			₽at	Date		Appli	cant's Parent/Legal Gu	iardian (ii applicable)			D1400E743E7 033E	