HPHC Insurance Company
DirigoChoice PPO Plan
Enrollment / Change Form

PO BOX 5225 • WESTBOROUGH, MA 01581
1-877-213-5225 www.healthplansinc.com

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

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

☐ **CHANGE**
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW
- ☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS
- ☐ MARRIAGE DATE _____
- ☐ NEWBORN DATE _____

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

TO BE COMPLETED BY HPHC ONLY.	GROUP / COMPANY NAME (IF APPLICABLE)	DATE OF HIRE	GROUP #/DIVISION (IF APPLICABLE)	EFFECTIVE DATE
H H D				

APPLICANT NAME

FIRST MIDDLE LAST

ADDRESS

APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

TYPE OF COVERAGE
☐ INDIVIDUAL ☐ 2-PERSON
☐ FAMILY ☐ OTHER _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE / DOMESTIC PARTNER 03 DEPENDENT CHILD UNDER 23
04 STEPCHILD UNDER 23 06 HANDICAPPED (VERIFICATION REQUIRED)

FIRST MI LAST (IF NOT SAME AS APPLICANT)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX		RELATION CODE	SOCIAL SECURITY NUMBER
APPLICANT		- -	M	F	01	- -
SPOUSE		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -
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 American Sign Language · CA Cantonese · CV Cape Verdean · EN English · FR French · HA Haitian · HM Hmong · IT Italian · KH Khmer · LO Laotian · MN Mandarin · PT Portuguese · RU Russian · SP Spanish · VI Vietnamese · OTHER ☐ _____ Specify

HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? ☐ 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 HPHC. Benefits under the Plan will be explained in a separate document. For an explanation of how HPHC may use or disclose your protected health information, please read your notice of privacy practices provided to you by HPHC in your enrollment kit. 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 by signing below, I am agreeing to the terms of the evidence of coverage. All statements and descriptions in this enrollment/change form are deemed to be representations and not warranties. I authorize any health care provider or other health plan to provide medical information and records to HPHC. I also authorize the plan and any health care provider rendering services to me or my dependents to receive copies of my or my dependents' medical records. I understand that any information obtained under this authorization will be used in the delivery of health services, to determine eligibility for benefits (including reimbursement by third parties), in education and research in accordance with government regulations, and in connection with HPHC's professional and utilization review activities. Permission is not given for any re-disclosure of this information other than as specified above. This authorization is valid for the term of the policy and any renewals of that policy. I understand that a copy of this form will be given to me, or my authorized representative, upon request. I understand that I may revoke this authorization, but that a revocation may be a basis for denying insurance benefits. Failure to sign this form may impair the ability of HPHC to evaluate or process your application or claim and may be a basis for denying an application or claims for benefits.

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 APPLICANT AND, IF APPLICABLE, THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

APPLICANT SIGNATURE _____ DATE _____ EMPLOYER SIGNATURE (IF APPLICABLE) _____ DATE _____