Enrollment / Change Form

SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

Harvard Pilgrim Health Care

A

FOR EMPLOYER USE ONLY	Effective Date	Hire Date	Employer Name: City of Laconia	Employer Address: 45 Beacon Street E, Laconia, NH 03246

☐ New Hire ☐ Open Enrollment | ☐ Active ☐ Retiree ☐ COBRA | Account Number | Branch Code | Billing Group

Type of Change: See Qualifying Events on Reverse

☐ Address Change ☐ Add Dependent(s): List names in Section B ☐ Retirement

☐ Cancel Employee* ☐ Cancel Dependent(s)*_____ ☐ Other: _____

**Must also complete COBRA Notification Request Form*

B

Employee Name *(last)* *(first)* *(M.I.)* | Social Security #

Cell Phone | Home Phone | E-Mail Address

Mailing Address *(Street, Apt #, or PO Box)* *(City)* *(State)* *(Zip Code)*

Last Name	**First Name**	**M.I.**	**Social Security #**	**Date of Birth**	**PCP Name & ID #**	**Gender**	**Relationship to Subscriber** i.e. legally married, *domestic partner, biological, step or adopted child (*not all Employers offer DP coverage)
Employee						☐ M ☐ F	Spouse E-mail Address
Spouse (whom you wish to cover)						☐ M ☐ F	☐ Legally Married ☐ Domestic Partner*
Dependent (whom you wish to cover)						☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted
Dependent (whom you wish to cover)						☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted
Dependent (whom you wish to cover)						☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted

C

Medical Plan Options

☐ HMO Super $1,500 Rx 10%
☐ POS $20/$40 $1,500 Rx Retail $10/30/50; Mail $15/45/70

☐ ElevateHealth Options $2,000 Rx $5/15/30/50

If declining coverage, please initial below.

_____ **Decline Medical Coverage**

D

Other Health Care Coverage **Will you or your covered dependents have other health insurance while on SCHOOLCARE? ☐ Yes ☐ No**

Name of person covered	ID Number or Medicare No.	Effective Date	Name of Carrier	Medicare Part A	Medicare Part B	Medicaid	Other Insurance Carrier
1.				☐	☐	☐	☐
2.				☐	☐	☐	☐

Signature – The information provided above is true and correct to the best of my knowledge.

E

Employee's Signature/ Date | Employer's Signature / Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

Please review additional information on reverse side of this Form.

☐ I understand that checking this box constitutes a legal signature confirming that I have reviewed the information on this Form.

INSTRUCTIONS

EMPLOYER

Complete Section A - Employer and enrollment/change information
Check box(es) indicating reason(s) for submitting enrollment/change request.

Complete Section E - in the lower right hand corner of the Form
Employer must sign and date the Form after reviewing all information in order for It to be processed.

EMPLOYEE – Complete Sections B - E

Section B - Employee and Covered Dependent Information
Complete all information in order for your enrollment/change request to be processed.

- *Provide **LEGAL NAME AND MIDDLE INITIAL** for all enrollees.*
- *Federal regulations require **social security numbers** for all enrollees.*
- Provide ***valid email address(es)*** to be sure you receive information regarding wellness cash incentives.
- Primary Care Provider: If your plan is an HMO or POS, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away.
- Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only.
- To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section or call 1-888-333-4742

Section C - Plan Option

Check one SCHOOLCARE medical plan option box that you are selecting as offered by your employer.

If declining coverage, initial accordingly.

Section D - Other Health Care Coverage

Only complete for covered dependents on the plan who will maintain other insurance while on SCHOOLCARE.

Section E - Employee Verification

Employee must sign and date the Form after completing and reviewing all information in order for it to be processed.

QUALIFYING EVENTS

For a qualifying event, subscribers must provide notice within **30 days** of the event. Examples include:

- Marriage
- Loss of other insurance coverage
- Adoption/ Legal Guardianship
- Birth of a child
- Death
- Divorce/ Legal Separation (Subscriber or Spouse notification within 60 days)

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, SCHOOLCARE or Harvard Pilgrim Health Care do not waive any terms of its contracts. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, SCHOOLCARE,or Harvard Pilgrim Health Care do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 plan.

HARVARD PILGRIM HEALTH CARE PROVISIONS

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC).
2. I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINSTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES.
3. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS.
4. 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 DENIAL OF INSURANCE BENEFITS.