Harvard Pilgrim Health Care *in partnership with* Small Business Service Bureau, Inc.

38 Austin Street
Worcester, Ma 01609
1-800-472-7199

2024 Member Enrollment / Change Form

Health Insurance Plan (check one):

- ❑ HMO 20 – Flex
- ❑ HMO 500 – Flex
- ❑ HMO 1000 – Flex
- ❑ HMO 2000 – Flex
- ❑ HMO HSA 3400 – Flex
- ❑ HMO 3500 – Flex
- ❑ PPO 3000 – Flex
- ❑ PPO HSA 3400 – Flex

Coverage Type (check one):

- ❑ Self
- ❑ Self + Spouse
- ❑ Self + Dependent child/ren
- ❑ Family

Effective Date Enrollment/Change/Cancellation:

/ /

Enrollment Application (check one):

- ❑ New Enrollment
- ❑ Renewal
- ❑ Enrollment Change
- ❑ Enrollment Cancellation
- ❑ Loss of Insurance
- ❑ Add/Delete Dependent(s)
- ❑ Other (please describe) _____

Subscriber Information

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner (circle one): same sex or opposite sex

IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN. AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.

FIRST MI LAST (IF NOT THE SAME AS EMPLOYEE)	DATE OF BIRTH MO DAY YR	SEX		RELATION CODE	SOCIAL SECURITY NUMBER*	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?		DO NOT WRITE PCP#
SUBSCRIBER	- -	M	F	O1	- -		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	

*Social security number(s) on application (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. *(Social security numbers are not displayed on the member's ID card.)*

I understand that membership will become effective when accepted by the plan. I understand that my covered benefits under this plan will be explained in a separate document, which may be revised from time to time. During my membership I authorize any health care provider or other health plan to provide medical information and records to the plan or plan affiliated health care providers. 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 and entitlement to benefits (including reimbursement by third parties), in education and research in accordance with government regulations, and in connection with the plan's professional and utilization review activities. Permission is not given for any redisclosure of this information other than as specified above. I understand that a copy of this form will be given to me, or to my authorized representative, upon request. final premium rates will be based on plan's receipt of a completed enrollment application, which includes this application and the first month's premium. We reserve the right to withdraw or recalculate rates that were based on incomplete or inaccurate information. A complete and accurate enrollment application must be received by HPHC at least five (5) days before the first day of the month for which you request coverage. If plan receives your complete enrollment application after this date, your coverage will be re-rated and will begin the following month.

COVERAGE UNDERWRITTEN OR ADMINISTERED BY HARVARD PILGRIM HEALTH CARE, INC. OR ITS AFFILIATE, HPHC INSURANCE COMPANY HEALTH CARE,INC.

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 MUST SIGN AND DATE THIS FORM FOR ENROLLMENT. IF THE APPLICANT IS A CHILD UNDER AGE 19, THIS FORM MUST INSTEAD BE SIGNED BY A PARENT OR LEGAL GUARDIAN.

APPLICANT SIGNATURE	DATE	APPLICANT'S PARENT/LEGAL GUARDIAN (IF APPLICABLE)	DATE

HOME STREET ADDRESS

CITY STATE ZIP CODE

HOME OR CELL PHONE NUMBER

MAILING ADDRESS **(IF DIFFERENT)**

CITY STATE ZIP CODE

EMAIL ADDRESS

Steps to Complete Enrollment: You must complete these steps to ensure that your coverage will begin by the effective date you selected.

- ❑ **1** Complete this application (Choose a plan, select an effective date, and sign application)
- ❑ **2** The first month's full premium payment
- ❑ **3** Proof of Massachusetts residency *(our Non-Group Health Plans are for Massachusetts residents only)*
- ❑ **4** Application outside of Open Enrollment requires proof of qualifying life event for enrollment *(Open Enrollment begins 11/1 for an effective date of 1/1 each year)*

Mail your completed materials to:
Small Business Service Bureau, Inc.
38 Austin Street
Worcester, MA 01609

Fax materials to:
Small Business Service Bureau, Inc.
508-792-3872

Or Email to:
info@sbsb.com

Remember to include a copy of your premium quote.

Questions? Please call us at: 1-800-472-7199

IMPORTANT: Our health plans are for Massachusetts residents only. Proof of residency is required before your coverage begins.