

Neighborhood Health Plan

Enrollment and Change Form

253 Summer Street, Boston, MA 02210-1120
 TEL: 617-772-5500 / 1-800-433-5556 FAX:617-772-5513

PLEASE FILL OUT ALL SECTIONS (UNLESS OTHERWISE INDICATED) USING BALLPOINT OR ROLLERBALL PEN. PRESS DOWN HARD.

Group Information & Effective Date	NHP Group Number		Work Site of Applicant						
	Employer Name								
Employee Information	Date of Employment	Month	Day	Year	Effective Date of Coverage	Month	Day	Year	
	Your Primary Care Site		Your Primary Care Physician (Last, First)						
Employee Last Name					First Name			M.I.	Sex (M/F)
Date of Birth		Month	Day	Year	Social Security Number		Home Phone ()		Work Phone ()
Street/Mailing Address				Apartment / P.O. Box #		City		State	Zip Code

CHECK ALL THAT APPLY:(To be completed by employer)

APPLICATION FOR ENROLLMENT	CHANGE IN ENROLLMENT
<input type="checkbox"/> New Employee	<input type="checkbox"/> Adding dependent(s)
<input type="checkbox"/> Annual Enrollment	<input type="checkbox"/> Deleting dependent(s)
<input type="checkbox"/> COBRA continuation request	<input type="checkbox"/> Termination - Effective Date: _____
<input type="checkbox"/> Conversion to "DIRECT BILL" status	<input type="checkbox"/> Primary Care Physician / Site
<input type="checkbox"/> Product change	<input type="checkbox"/> Product Change
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
REASON FOR CHANGE IN ENROLLMENT STATUS	
<input type="checkbox"/> Death or Divorce	<input type="checkbox"/> Covered under other Group Plan
<input type="checkbox"/> Enrolled in Medicare	<input type="checkbox"/> Other (Describe) _____
<input type="checkbox"/> RIDERS (Specify) _____	

Language What language do **YOU** speak most often? Please check the appropriate box. Knowing the main language spoken by you and your family members (see below) will help us to better serve your needs.

<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15	<input type="checkbox"/> 16	_____ (Please specify)
Armenian	Cantonese	Cape Verdean Creole	English	French	Haitian Creole	Hmong	Italian	Khmer	Laotian	Mandarin	Portugese	Russian	Spanish	Vietnamese	Other	(Please specify)

Coverage **TYPE OF NHP COVERAGE** (Check one only)

Individual Individual + 1 (where offered) Family

In addition to NHP, my spouse or children are covered by a health plan offered by:

Employer: _____ Insurance Co./HMO Name: _____ Policy No. _____ Effective Date Month Day Year

Are you (and/or your spouse) eligible for Medicare? Self Yes No If "yes" are you enrolled in: Medicare Part A Part B Provide Medicare # _____

If "yes" is your spouse enrolled in: Medicare Part A Part B Provide Medicare # _____

Please provide all information requested BELOW for any eligible dependents you wish to enroll.

	Last Name	First Name	M.I.	Sex M/F	Social Security No.	Other Insur.	Date of Birth	Full Time Student	Primary Care Site	Primary Care Physician (Last Name, First Initial)	Language (Use language code above)
Spouse:						Y <input type="checkbox"/> N <input type="checkbox"/>	Mo. Day Yr.				
Child:						Y <input type="checkbox"/> N <input type="checkbox"/>	Mo. Day Yr.	Y <input type="checkbox"/> N <input type="checkbox"/>			
Child:						Y <input type="checkbox"/> N <input type="checkbox"/>	Mo. Day Yr.	Y <input type="checkbox"/> N <input type="checkbox"/>			
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Child:						Y <input type="checkbox"/> N <input type="checkbox"/>	Mo. Day Yr.	Y <input type="checkbox"/> N <input type="checkbox"/>			

Acknowledgement: The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions of my applicable premium amounts. I assign benefits to NHP for the cost of services when the liability for payment is the responsibility of another health insurance plan/HMO, worker's compensation plan or other coverage. I (we) agree that NHP and its affiliated Health Care Providers, may obtain or release my (our) medical information including medical records, medical coverage available or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. I (we) understand that for NHP coverage to be in effect when medical care supplies are obtained, all care & supplies must be authorized and provided by participating primary care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Por la presente autorizo a mi empleador hacer las deducciones necesarias para la prima de seguro de mi nómina de pago. Asigno (asignamos) beneficios a NHP por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores u otro tipo de cobertura. Estoy (estamos) de acuerdo que NHP y sus Proveedores de Cuidado de Salud afiliados pueden obtener o divulgar mi(nuestra) información médica, incluyendo registros médicos, cobertura médica disponible u otra información médica, con el propósito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médicas y/o cuando es requerida por la ley. Yo entiendo (entendemos) que para que la cobertura de NHP tenga vigencia para la obtención de suministros médicos, toda la atención y suministros deben ser autorizados y proporcionados por un médico de cuidado primario participante autorizado (según se indica arriba).

ALL INFORMATION MUST BE COMPLETE AND FORM SIGNED BEFORE PROCESSING CAN BEGIN

Employee's Signature: _____ Date: _____

Employer's Signature: _____ Date: _____

Contact Name (Please print): _____ Tel: _____

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Date of Birth		Month	Day	Year	Social Security Number		Home Phone ()		Work Phone ()
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Child:						Y <input type="checkbox"/> N <input type="checkbox"/>	Mo. Day Yr.	Y <input type="checkbox"/> N <input type="checkbox"/>			
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Employee's Signature: _____ Date: _____	Employer's Signature: _____ Date: _____ Contact Name (Please print): _____ Tel: _____

Welcome to Neighborhood Health Plan

NHP membership begins on the "effective date" specified on the reverse side of this application form. We will mail information to you about NHP approximately one week following receipt of your application from your employer. In the meanwhile, please keep this copy as your temporary NHP identification.

If you need care between the time your coverage becomes effective and the time you receive your NHP membership card, please call the physician and primary care site you have chosen.

To be covered for services in the NHP Enrollment Area or within 20 miles of your home, your health care must be provided or arranged by NHP. Consequently, in a medical emergency within this area, you must call your physician and primary care site before seeking care. Detailed information about the NHP benefits and procedures (including out of area coverage) is available in the NHP Subscriber Agreement. "Riders" signify value-added benefits for which additional premiums may be charged. If you have any questions about membership, benefits, services, or procedures, please call Member Services at (617) 772-5500 or 1-800-433-5556.

We're glad you have chosen Neighborhood Health Plan and look forward to meeting your health care needs.

Please write your primary care site, physician and telephone number here.

Por favor, escriba el nombre de su centro de cuidados primario, su médico, y su número de teléfono aquí.

Bienvenido al "Neighborhood Health Plan"

La membresía del NHP comienza en la "fecha efectiva" especificada al dorso de esta solicitud. Le enviaremos información sobre el NHP aproximadamente una semana después de haber recibido esta solicitud de su empleador. Mientras tanto, por favor guarde esta copia como su identificación temporaria del NHP.

Su Ud. necesita cuidado médico entre la fecha de efectividad de su póliza y la fecha cuando Ud. recibirá su tarjeta de miembro de NHP, por favor llame al médico y al centro de cuidados primario que usted ha escogido.

Para estar cubierto/a para servicios dentro del Area de Inscripción del NHP, o para obtener servicios dentro de un área de 20 millas alrededor de su casa, su cuidado médico debe ser proveído o arreglado por el NHP. Por consiguiente, en caso de una emergencia dentro de esta área, Ud. debe llamar a su médico o centro de cuidados primario antes de buscar cualquier tipo de cuidado. La información detallada sobre los beneficios y procedimientos del NHP (incluso la información sobre cuidado fuera de su área) está disponible en el Acuerdo del Subscriptor del NHP. "Cláusulas añadidas" significan beneficios adicionales por los cuales se puede cobrar costos adicionales. Si Ud. tiene cualquier tipo de pregunta sobre la membresía, los beneficios, los servicios, o los procedimientos del plan, favor de llamar al Departamento de Servicios para Miembros, al (617) 772-5500 o 1-800-433-5556.

Nos alegra que haya Ud. escodigo el "Neighborhood Health Plan," y esperamos poder servirle en todo lo que sea que trata del cuidado de su salud.