



# Enrollment and Change Form

253 Summer Street, Boston, MA 02210-1120  
Tel 800-462-5449 Fax 617-772-5513

Please use a ballpoint pen and press down firmly.

<b>Application for Enrollment</b> <input type="checkbox"/> New Employee <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> COBRA Continuation <input type="checkbox"/> Involuntary Loss of Prior Group Coverage * <input type="checkbox"/> Other _____ <b>Termination Effective Date:</b> _____ <b>Change in Enrollment Date:</b> _____ <input type="checkbox"/> Adding Dependents <input type="checkbox"/> Deleting Dependents <input type="checkbox"/> Primary Care Physician / Site Change <input type="checkbox"/> Other _____ <input type="checkbox"/> * <b>Documentation Required</b>	<b>Reason for Change in Enrollment</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption of Child * <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent Attending School* <input type="checkbox"/> Left Employ <input type="checkbox"/> Moved Out of Service Area <input type="checkbox"/> Voluntary <input type="checkbox"/> Loss of Student Eligibility <input type="checkbox"/> Ineligible Dependent <input type="checkbox"/> Death (need exact date) <input type="checkbox"/> Reached Age 65
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Group Information & Effective Date	NHP Group Number							
	Employer Name							
	Date of Employment	Month	Date	Year	Effective Date of Coverage	Month	Date	Year

Employee Information	Your Primary Care Site				Your Primary Care Physician (Last, First)					
	Last Name				First Name				M.I.	Sex m/f
	Date of Birth (mo/day/year)		Social Security Number		Home Phone - include area code			Work Phone - include area code		
	Street / Mailing Address				Apartment / PO Box		City		State	Zip Code

Language: What language do YOU speak most often? Please check the appropriate box. Knowing the main language spoken by your 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
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)	<input type="checkbox"/> Individual	<input type="checkbox"/> Individual/Spouse	<input type="checkbox"/> Individual/child or children	<input type="checkbox"/> Family	In addition to NHP, my spouse or children are covered by a health plan offered by: _____ Effective Date: ____/____/____								
	Are you (and/or your spouse) eligible for Medicare?	<input type="checkbox"/> Self	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If 'yes' are you enrolled in:	Medicare Part A	Medicare Part B	Your Medicare Number: _____	If 'yes' is your spouse enrolled in:	Medicare Part A	Medicare Part B

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

	Last Name	First Name	MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth Mo Day Year	Full Time Student	Primary Care Site	Primary Care Physician (Last Name, First Initial)	Language (use code above)
Spouse:						<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N			
Child:						<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N			
Child:						<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N			
Child:						<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N			
Child:						<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N			

**Acknowledgement:** The information supplied on this form is true and complete. I assign benefits to Neighborhood Health Plan (NHP) for the cost of services when the liability for payment is the responsibility of another 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 and supplies must be authorized and provided by participating care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. 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 o 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 medicos, cobertura médica disponible o otra información médica, con el propósito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica 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 todos los suministros deben ser autorizados y proporcionados por un medico de cuidado primario participante autorizado (segun se indica arriba).

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

Employer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name (Please print): \_\_\_\_\_ Telephone: \_\_\_\_\_

**RETURN THIS ORIGINAL TO NEIGHBORHOOD HEALTH PLAN**

## Welcome to Neighborhood Health Plan

NHP membership from your employer begins on the “effective date” specified on the reverse side of this application form. We will mail information to you about NHP approximately two weeks following receipt of your application. In the meanwhile, please keep the pink copy of this application 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 your health care must be provided or arranged by NHP. Detailed information about the NHP benefits and procedures (including out-of-area coverage) is available in the NHP Member Handbook. If you have questions about membership, benefits, services, or procedures, please call Member Services at 800-462-5449.

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 above.

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

Usted es miembro del NHP a través de empleador a partir de la “fecha de vigencia” (“effective date”) especificada en el reverso de este formulario de solicitud. Le enviaremos información por correo sobre el NHP aproximadamente dos semanas después de que hayamos recibido su solicitud. Entretanto, guarde la copia rosa de su solicitud como su identificación temporal del NHP. Si necesita atención entre la fecha en que su cobertura pasa a ser efectiva y la fecha en que recibe su tarjeta de miembro del NHP, llame al médico y al lugar de atención primaria que eligió.

Para estar cubierto para servicios en la Zona de Inscripción del NHP, la atención de su salud debe ser provista por el NHP o el NHP debe hacer los arreglos para ella. Para información detallada sobre los beneficios y procedimientos del NHP (incluyendo la cobertura fuera de la zona), consulte el Manual del Miembro del NHP. Si tiene preguntas sobre ser miembro, los beneficios, los servicios o los procedimientos del NHP, llame a Servicios a los Miembros al 800-462-5449.

Nos complace que haya elegido el Neighborhood Health Plan y tendremos mucho gusto en cumplir con sus necesidades de atención de la salud.

**Notice of Privacy Practices:** We may collect information from your health care providers and other insurance companies to help us determine your coverage and administer your benefits. The information we collect will not be released to another party without your permission, except as authorized by law. You have the right to access the information we collect and to request a correction of any information you believe is incorrect. A more detailed description of our privacy practices is available upon written request. Please call Member Services at 800-462-5449 if you have questions or to obtain a copy of our privacy practices.