

Please use a ball point pen and press down firmly.

Application for Enrollment

- New employee
- Annual enrollment
- COBRA Continuation
- Involuntary loss of prior group coverage*
- Other _____

*Documentation required

Change in Enrollment

- Adding dependents
- Deleting dependents
- PCP/Site change
- Termination
- Employee/dependent demographics
- Other _____

Reason for Change in Enrollment

- Marriage
- Birth of child
- Adoption of child*
- Divorce
- Left employment
- Reached age 65
- Adding disabled dependents
- Moved out of service area
- Voluntary
- Loss of dependent eligibility
- Death, exact date _____

Group Information									
NHP group number				Employer name					
Date of employment	Month	Day	Year	Effective Date	Month	Day	Year	Plan design	

Employee Information									
Last name					First name				M.I.
Date of birth (mm/dd/yy)		Social Security Number			Gender (m/f)	Home phone – Include area code		Work phone – Include area code	
Street mailing address				Apt.	P.O. Box	City		State	Zip code

If the Primary Care Physician (PCP) you choose is not in the NHP network, one will be selected for you. For help finding a PCP, please go to nhp.org and use our Provider Search Tool under the "Find a Provider" link. You may change your PCP assignment at any time.

PCP and Site Information	
Primary care site	
Your Primary Care Physician (Last name, First, M.I.)	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Language	
What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.	
<input type="checkbox"/> English (04) <input type="checkbox"/> Spanish (14) <input type="checkbox"/> French (05) <input type="checkbox"/> Haitian Creole (06) <input type="checkbox"/> Portuguese (12) <input type="checkbox"/> Russian (13) <input type="checkbox"/> Cape Verdean Creole (03) <input type="checkbox"/> Cantonese (02) <input type="checkbox"/> Mandarin (11) <input type="checkbox"/> Vietnamese (15) <input type="checkbox"/> Other (16), please specify _____	

Group Coverage			
Type of NHP coverage (check only one)	In addition to NHP, my spouse or children are covered by a health plan offered by:		
<input type="checkbox"/> Self <input type="checkbox"/> Individual & spouse <input type="checkbox"/> Individual & child/children <input type="checkbox"/> Family	Employer	Insurance co. name	Policy #
Are you and/or your spouse eligible for Medicare?	Self <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are you enrolled in <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B	Your Medicare policy number
		If yes, is your spouse enrolled in <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B	Your spouse's Medicare policy number

Please provide **ALL** information below for any eligible dependents you wish to enroll.

Spouse last name		First name		M.I.	Primary care site		Existing patient?
Date of birth	Social Security Number	Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site		Existing patient?
Date of birth	Social Security Number	Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site		Existing patient?
Date of birth	Social Security Number	Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site		Existing patient?
Date of birth	Social Security Number	Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent last name		First name		M.I.	Primary care site		Existing patient?
Date of birth	Social Security Number	Gender (m/f)	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care physician (last name, first name, M.I.)		<input type="checkbox"/> Yes <input type="checkbox"/> No

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 completed and form signed before processing can begin	
Employer contact name (please print): _____ Phone: _____	Employee's signature: _____ Date: _____
Employer's signature: _____	Date: _____