

Please use a ballpoint pen and press down firmly.

Application for Enrollment

- New Employee
 Annual Enrollment
 COBRA Continuation
 Involuntary Loss of Prior Group Coverage *
 Other _____
 Termination
 Termination Effective Date _____

Change in Enrollment

- Date: _____
 Adding Dependents
 Deleting Dependents
 Primary Care Physician / Site Change
 Other _____

Reason for Change in Enrollment

- Marriage
 Birth of Child
 Adoption of Child *
 Divorce
 Non-IRS Dependent
 * Documentation Required
- Left Employment
 Moved Out of Service Area
 Voluntary
 Loss of Dependent Eligibility
 Death (need exact date)
 Reached Age 65

Group Information	
NHP Group Number	

Employer Name							
Date of Employment	Month	Day	Year	Effective Date of Coverage	Month	Day	Year

If the Primary Care Physician (PCP) you choose is not in the NHP network, one will be selected for you. You may change your PCP assignment at any time.

Employee Information

Last Name				First Name				M.I.	Sex M/F
Date of Birth (mm/dd/yy)		Social Security Number		Home Phone – Include area code			Work Phone – Include area code		
Street Mailing Address				Apartment	PO Box	City		State	Zip Code

PCP and Site Information

Primary Care Site	Primary Care Site #
Your Primary Care Physician (Last, First, Middle Initial)	PCP #

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"/> 04 English	<input type="checkbox"/> 14 Spanish	<input type="checkbox"/> 05 French	<input type="checkbox"/> 06 Haitian Creole	<input type="checkbox"/> 12 Portuguese	<input type="checkbox"/> 13 Russian	<input type="checkbox"/> 03 Cape Verdean Creole	<input type="checkbox"/> 02 Cantonese	<input type="checkbox"/> 11 Mandarin	<input type="checkbox"/> 15 Vietnamese	_____ Other, please specify	<input type="checkbox"/> 16
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Group Coverage

Type of NHP Coverage	<input type="checkbox"/> Self	<input type="checkbox"/> Individual/Spouse	In addition to NHP, my spouse or children are covered by a health plan offered by:				Effective Date				
Check one only	<input type="checkbox"/> Individual/ Child or Children	<input type="checkbox"/> Family	Employer:	Insurance Co./HMO Name:	Policy No:	/ /					
Are you (and/or your spouse) eligible for Medicare:	<input type="checkbox"/> Self	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If 'yes' are you enrolled in:	Medicare Part A	Medicare Part B	Medicare Number	If 'yes' is your spouse enrolled in:	Medicare Part A	Medicare Part B	Your Spouse's Medicare Number

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

Spouse Last Name:		First Name		MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
							<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
Primary Care Site		Primary Care Site#		Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
								<input type="checkbox"/> Y <input type="checkbox"/> N	

Dependent Last Name:		First Name		MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
							<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
Primary Care Site		PCP Site #		Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
								<input type="checkbox"/> Y <input type="checkbox"/> N	

Dependent Last Name:		First Name		MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
							<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
Primary Care Site		PCP Site#		Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
								<input type="checkbox"/> Y <input type="checkbox"/> N	

Dependent Last Name:		First Name		MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
							<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N
Primary Care Site		PCP Site#		Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
								<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 médicos, 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 médico de cuidado primario participante autorizado (según se indica arriba).

ALL INFORMATION MUST BE COMPLETED AND FORM SIGNED BEFORE PROCESSING CAN BEGIN		Employer's Signature: _____	Date: _____
Employee's Signature: _____	Date: _____	Contact Name: (Please print) _____	Telephone: _____

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 our Customer Care Center at 800-462-5449 or TTY 800-644-1761.

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.