HPHC Insurance Company
Medicare Enhance

P.O. BOX 9185 • QUINCY, MA 02169
1-888-888-HPHC(4742)

CHECK ONE

☐ ENROLLMENT _____ (REASON FOR ENROLLING) _____ EFFECTIVE DATE

☐ TERMINATION _____ (REASON FOR TERMINATION) _____ LAST DAY OF COVERAGE

☐ ADJUSTMENT _____ (REASON FOR CHANGE is: ADDRESS, NAME, ETC.) _____ EFFECTIVE DATE

INSTRUCTIONS

- **DO NOT WRITE IN SHADED AREAS**
- **PLEASE TYPE OR PRINT FIRMLY**
- **ATTACH A COPY OF MEDICARE CARD**

ID NUMBER
H P E

GROUP NO. | DIV. NO.

NAME — FIRST — MIDDLE — LAST

HOME PHONE # ( )

MAILING ADDRESS — NO. STREET/P.O. BOX — CITY — STATE — ZIP — APT # — COUNTY

SOCIAL SECURITY # — —

HOME ADDRESS — NO. STREET/P.O. BOX — CITY — STATE — ZIP — APT # — COUNTY

DATE OF BIRTH MO/ DAY/ YR/

SEX M ☐ F ☐

LANGUAGE CODES

WHAT LANGUAGE DO *YOU* SPEAK MOST OFTEN? → **PLEASE CIRCLE** ← THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

ASL American Sign Language | CA Cantonese | CV Cape Verdean | EN English | FR French | HA Haitian | HM Hmong | IT Italian | KH Khmer | LO Laotian | MN Mandarin | PT Portuguese | RU Russian | SP Spanish | VI Vietnamese | OTHER ☐ _____ Specify

ARE YOU CURRENTLY A RESIDENT OF A NURSING HOME? ☐ YES ☐ NO IF YES, GIVE NAME & ADDRESS OF NURSING HOME AND ADMIT DATE BELOW:

NAME — ADDRESS — ADMIT DATE / /

FORMER/CURRENT EMPLOYER — EMPLOYER PHONE # — DATE OF RETIREMENT (IF APPLICABLE) / /

DATE OF DISABILITY (IF APPLICABLE) / /

ARE YOUR CURRENTLY A HARVARD PILGRIM HEALTH CARE MEMBER?

☐ YES ☐ NO

IF YES LIST ID # BELOW:

ID #

A COPY OF YOUR MEDICARE CARD MUST ACCOMPANY THIS FORM IN ORDER TO PROCESS YOUR ENROLLMENT.

IF YOU ARE UNDER AGE 65, IS THE ILLNESS OR CONDITION WHICH QUALIFIES YOU FOR MEDICARE END STAGE RENAL DISEASE? YES ☐ NO ☐

IF YES, WHAT IS YOUR ENTITLEMENT DATE? _____ .

IF NO, STATE THE ILLNESS OR CONDITION WHICH QUALIFIES YOU FOR MEDICARE.

HAVE YOU HAD A KIDNEY TRANSPLANT? YES ☐ NO ☐

ARE YOU COVERED BY MEDICAID? YES ☐ NO ☐ IF YES, MEDICAID NUMBER _____

ARE YOU CURRENTLY A MEMBER OF ANOTHER MEDICAL INSURANCE PLAN (EXCLUDING MEDICARE)? YES ☐ NO ☐

IF YES, PLEASE INDICATE NAME OF PLAN _____ SUBSCRIBER NAME _____

EFFECTIVE DATE _____ POLICY # _____

I UNDERSTAND THAT MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN AND THAT BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. DURING MY MEMBERSHIP, I AUTHORIZE ANY HEALTH CARE PROVIDER OR OTHER HEALTH PLAN TO PROVIDE MEDICAL INFORMATION AND RECORDS TO THE PLAN, THE PLAN ADMINISTRATOR, OR PLAN AFFILIATED HEALTH CARE PROVIDERS. I ALSO AUTHORIZE THE PLAN, THE PLAN ADMINISTRATION, AND ANY PLAN HEALTH CARE PROVIDERS RENDERING SERVICES TO ME TO RECEIVE COPIES OF MY MEDICAL RECORDS. I AUTHORIZE THE USE BY THE PLAN, AND ITS AGENTS, OF ANY INFORMATION OBTAINED HEREUNDER FOR THE DELIVERY OF HEALTH SERVICE, TO DETERMINE ELIGIBILITY AND ENTITLEMENT TO BENEFITS (INCLUDING REIMBURSEMENT BY THIRD PARTIES), FOR EDUCATION AND RESEARCH IN ACCORDANCE WITH GOVERNMENT REGULATIONS, AND FOR THE OTHER PLAN PROFESSIONAL ACTIVITIES SUCH AS UTILIZATION REVIEW, QUALITY ASSURANCE, CASE MANAGEMENT, REFERRAL AND AUTHORIZATION, DISEASE MANAGEMENT, FRAUD DETECTION AND CERTAIN OVERSIGHT ACTIVITIES, SUCH AS ACCREDITATION AND REGULATORY AUDITS. I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR TO MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

THE EMPLOYEE MUST SIGN THIS FORM FOR ENROLLMENT.

_____ EMPLOYEE SIGNATURE _____ DATE _____ EMPLOYER SIGNATURE _____ DATE