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	GROUP NO.	DIV. NO.
H P E		

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 ☐

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.
THIS PLAN PROVIDES LIMITED BENEFITS. PLEASE READ YOUR POLICY CAREFULLY.

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 #_____

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN. 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 ADMINISTRATOR, 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. FOR AN EXPLANATION OF HOW HPHC INSURANCE COMPANY MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HPHC INSURANCE COMPANY IN YOUR ENROLLMENT KIT. MAINE MEMBERS: PLEASE NOTE THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS. THIS AUTHORIZATION IS VALID THROUGH THE TERM OF COVERAGE UNDER THE PLAN OR ANY RENEWALS THEREOF. YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY CONTACTING THE PLAN AT THE ABOVE ADDRESS OR TELEPHONE NUMBER, PROVIDED THAT SUCH REVOCATION MAY BE A BASIS FOR DENYING BENEFITS UNDER THE PLAN. ALL STATEMENTS AND INFORMATION IN THIS FORM SHALL BE DEEMED REPRESENTATIONS AND NOT WARRANTIES. I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS. FAILURE TO SIGN THIS FORM MAY IMPAIR THE PLAN'S ABILITY TO EVALUATE OR PROCESS AN APPLICATION OR CLAIM AND MAY BE A BASIS FOR DENYING AN APPLICATION OR A CLAIM FOR BENEFITS

THE EMPLOYEE AND THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

EMPLOYEE SIGNATURE _____ DATE _____ EMPLOYER SIGNATURE _____ DATE _____