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 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. 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.
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.

THE EMPLOYEE MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

________________ EMPLOYEE SIGNATURE ________ DATE