HPHC Insurance Company

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

Med Enhance

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

- **PLEASE TYPE IN SPACES PROVIDED**
- **LEAVE BLUE SHADED AREAS BLANK**
- **ATTACH A COPY OF MEDICARE CARD**

ID NUMBER	GROUP NO.	DIV. NO.
H P		

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

CURRENT HPHC ID# (if any):

ID # _____

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) / /

PLEASE REFER TO YOUR MEDICARE CARD:

MEDICARE NUMBER _____

PART A EFFECTIVE DATE ___ / ___ / _____

PART B EFFECTIVE DATE ___ / ___ / _____

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