

Instructions to help you complete your enrollment application for the HPHC Medicare Supplement Plan

Maine

Thank you for applying for membership to HPHC's Medicare Supplement plan.

There are 3 ways to enroll:

1. Enroll online.
2. Enroll over the phone with a plan representative, please call **1-877-906-HPHC (4742)**.
3. Complete a paper enrollment application.

Prior to submitting your enrollment application for processing, please take the time to complete the entire enrollment application. If the enrollment application received is incomplete, it may be returned to you for additional information.

You are eligible to apply for HPHC's Medicare Supplement plan if you meet all of the following requirements:

- Your legal residence is in the state of Maine.
- You are eligible for Medicare Part A and Medicare Part B and enrolled in Medicare Part B.
- If you are under age 65 and qualify for Medicare coverage because of disability.
- Medicare Supplement benefit Plan F, will not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

Instructions:

1. Please choose a plan and effective date for coverage to begin (i.e. MM/01/YYYY). Your effective date begins the 1st of the month and cannot be prior to the date we receive your application.
2. Please fill in your personal information.
3. Your Medicare information: Copy information from your Medicare card, or attach a copy of your letter of Verification from the Social Security Administration or Railroad Retirement Board. If you don't have your Medicare information, call your local Social Security Office to obtain proof of enrollment.
4. Read and answer all questions in Section 4.

5. Determine your Eligibility.

Open Enrollment

- You have enrolled in Medicare Part B within the last 6 months.
- You were enrolled in Medicare Part B prior to age 65 and turned 65 within the last 6 months.
- Your Medicare Part B will become effective within the next 60 days.

Guaranteed Issue

- You have been involuntarily terminated or lost coverage from a Medicare Advantage Plan, employer retiree plan, COBRA coverage, Medicare Select, PACE, Demonstration or Medicare Supplement plan in the past 90 days.
- The Harvard Pilgrim Medicare Supplement plan you are choosing is of equal or lesser coverage than your current Medicare Supplement policy and you have not had a gap in coverage of more than 90 days.
(Please be sure to answer question 4 completely or HPHC may request proof of coverage).
- You left your employer retiree plan and are applying within 90 days of your disenrollment date.
- You voluntarily disenrolled from your Medicare Advantage, Medicare Select or PACE plan within the first 36 months of enrollment, and are applying for Medicare Supplement within 90 days of termination.

Annual One Month Guaranteed Issue

- You are applying for Plan "A" during the month of December for a January 1st effective date for coverage - Section 5 is **NOT** required.

Continuous Open Enrollment

- You are applying for Plans A, F, G, M and N at anytime-Section 5 must be completed with all "NO" responses.

6. Read "Important Information" in Section 6.
7. Sign and date the enrollment application.
8. If you received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement Insurance Policy, or that you had certain rights to buy such a Policy, please include a copy.

Detach the yellow copy of this application for your legal records and mail the white enrollment application to:

Harvard Pilgrim Health Care, Medicare Supplement Plan
1 Wellness Way, Canton, MA 02021

If you need assistance or have questions, please call us at: Prospective Members: 1-877-909-HPHC (4742), TTY 711

Current Members: 1-877-907-HPHC (4742), TTY 711

Maine
 New Enrollment
 Change to Enrollment

HPHC Medicare Supplement Enrollment Application

The Plan is underwritten by HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care.

SECTION 1.

Plan Choice: Plan A Plan F Plan G Plan M Plan N Plan Effective Date _____

SECTION 2.

Personal Information:

First Name _____ Middle Initial _____ Last Name _____

Permanent Address (Number & Street) _____

City/State/Zip Code _____

Billing Address (if different from your permanent address) _____

City/State/Zip Code _____

Current Insurance Carrier _____

Social Security Number
_____ — _____ — _____

Gender Male Female

Date of Birth Month _____ Day _____ Year _____

Telephone Number
() - _____

Email Address _____

SECTION 3.

Medicare Information

Please take out your red, white & blue Medicare Card to complete this section.

Name (as it appears on your Medicare card):

Medicare Number: _____

Is Entitled To: _____ Effective Date: _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Supplement plan.

SECTION 4.

Replacement or other Coverage

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement Insurance Policy, or that you had certain rights to buy such a Policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. If you were involuntarily terminated for nonpayment of premium, please also include documentation demonstrating payment of outstanding premiums.

SECTION 4. continued

Please Answer All Questions Please check Yes or No

To the best of your knowledge,

1. (a) Did you turn age 65 in the last six months? Yes No
(b) Did you enroll in Medicare Part B in the last six months? Yes No
(c) If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program?
NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. Yes No
If yes,
(a) Will Medicaid pay your premiums for this Medicare Supplement Insurance Policy? Yes No
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 90 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. If your previous coverage before this Medicare plan was a different Medicare plan of the same type, your "START" date is the day you began your **first** plan of this type.
START ____/____/____ END ____/____/____
(b) If you have been covered by more than one Medicare plan of this type, have you been covered continuously by these plans, with no break in coverage and no period of original Medicare (Part A or B) between the first plan and your current plan? Yes No
(c) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No

4. (a) Do you have another Medicare Supplement Insurance Policy in force? Yes No
(b) If so, with what company, and what plan do you have? _____

(c) If so, do you intend to replace your current Medicare Supplement Insurance Policy with this policy? Yes No

5. Have you had coverage under any other health insurance within the past 90 days? Yes No
(For example , an employer, union, or individual plan)
(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? START ____/____/____ END ____/____/____
(If you are still covered under this plan, leave "END" blank.)

SECTION 5.

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (SEE #5 ON THE INSTRUCTION PAGE TO DETERMINE WHETHER THIS SECTION APPLIES TO YOU), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

If the answer to any question in this section is YES the Applicant is not eligible for coverage. This does not apply to applicants applying for Medicare Supplement coverage under Plan A.

- Height _____ (feet/inches)
 - Weight _____ (pounds)
 - Are you now confined in a hospital or nursing home, or, within the past 60 days, have you been advised by a doctor to seek medical care or treatment in a hospital or in a nursing home? Yes No
 - Are you bedridden? Yes No
 - Do you require the use of a wheelchair? (if "YES," please give details) Yes No
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- Are you receiving kidney dialysis? Yes No
- Have you, due to mental or physical disability, authorized any person or institution to legally act in your behalf and take over your personal transactions? Yes No
- In the past 12 months, have you been advised to have surgery but it has not yet been done? Yes No
- In the past 12 months, have you been hospitalized three or more times? Yes No
- Do you routinely visit the same medical provider more than monthly for medical advice or treatment? Yes No
- Do you now have any of the following conditions diagnosed by a member of the medical profession or have you received medical advice or treatment for the following conditions within the past 12 months?
 - Cancer (except skin) or Leukemia
 - Chronic Lung Disease
 - Cirrhosis of the Liver
 - Diabetes (insulin dependent)
 - Stroke
 - Angina Pectoris, Heart Attack, Congestive Heart Failure, or Valvular Heart Disease
 - Alzheimer's Disease, memory loss or impairment, dementia or cognitive impairment
 - Parkinson's Disease
 - Multiple Sclerosis
 - Chronic Kidney Disease
 - Any form of Arthritis or Degenerative Bone Disease which causes crippling, fractures, limitation of motion or requiring joint replacement

SECTION 6.

IMPORTANT INFORMATION

- A. You do not need more than one Medicare Supplement policy.
- B. If you purchase this policy you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- C. You may be eligible for Medicaid benefits and may not need a Medicare Supplement policy.
- D. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- E. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.

If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- F. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION 7.

I or my authorized representative certify that the statements made and answers given are complete and true. I or my authorized representative have read and carefully considered all of the information on this application. I or my authorized representative also certify that I received the "Outline of Medicare Supplement Coverage." I or my authorized representative understand that no employer, former employer, health care provider, or private or government agency may sponsor, purchase or contribute to the cost of this Harvard Pilgrim Medicare Supplement Plan. I or my authorized representative understand that to enroll in coverage, and for as long as I am covered, I must be entitled to Medicare Part A and enrolled in Medicare Part B. I or my authorized representative understand that membership will become effective upon the first day of the month following acceptance by the Plan. Benefits under this Plan will be explained under a separate document.

I or my authorized representative authorize all of my health care providers, other health plans, and insurance companies to release all of my medical records and other information to the Plan or to Plan affiliated health care providers for the purpose of determining my coverage and administering my benefits.

I or my authorized representative 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 or my authorized representative understand that the benefits for which I am eligible are those described in the applicable subscriber policy. I or my authorized representative understand that HPHC's Medicare Supplement Insurance premium rates are subject to change as allowed by state law. I or my authorized representative understand that enrollment in this plan is contingent upon payment of premium. I or my authorized representative is entitled to receive a copy of this authorization application.

The subrogation provision outlined in the Policy, 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 application shall be deemed representations and not warranties. I understand that a copy of this application 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 application 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.

Signature of Applicant or Authorized Representative (if applicable)*

Date

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).

SECTION 8.

NOTE: THIS SECTION IS ONLY TO BE COMPLETED IF YOU ARE WORKING WITH AN INDEPENDENT INSURANCE AGENT. PLEASE FAX ENROLLMENT FORM TO 1-617-509-4262.

I, or my authorized representative, acknowledge receipt of "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" at the time of my application for coverage in Harvard Pilgrim Health Care's Medicare Supplement Plan.

Please Print:

Applicant Name: _____

Applicant Address: _____

Medicare Number : _____

Signature of Applicant, or Authorized Representative (if applicable)*

Date

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).

Please Print:

Agent/Broker Name _____

Agent /Broker ID _____

Agent /Broker Signature

Date

SECTION 9.

NOTE: THIS SECTION IS ONLY TO BE COMPLETED IF YOU ARE WORKING WITH AN INDEPENDENT INSURANCE AGENT AND ARE REPLACING AN EXISTING MEDICARE PLAN.

**NOTE: NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

HPHC Insurance Company, 1 Wellness Way, Canton, MA 02021

Save this Notice! It May be Important to you in the future.

According to the information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by HPHC Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, INSURANCE PRODUCER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- | | |
|--|---|
| <input type="checkbox"/> Additional benefits | <input type="checkbox"/> No change in benefits, but lower premiums |
| <input type="checkbox"/> Fewer benefits and lower premiums | <input type="checkbox"/> Disenrollment from a Medicare Advantage plan. |
| <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D. | Please explain reason for disenrollment. Optional only for Direct Mailers _____ |
| <input type="checkbox"/> Other (please specify) _____ | _____ |

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it. If you cancel your present Policy and then decide that you do not want to keep your new Policy, it may not be possible to get back the coverage of the present Policy.

Signature of Agent, Broker, or Other Representative*

Typed Name and Address of Issuer, Agent, or Broker

Please Print: Applicant Name _____
Applicant Address _____

Signature of Applicant or Authorized Representative (if applicable)*

Date

* If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).