Harvard Pilgrim Health Care

THIS ENROLLMENT APPLICATION IS IN SECTIONS-PLEASE REMOVE THIS TAB TO SEPARATE THE SECTIONS BEFORE YOU BEGIN

Enrollment Form

Harvard Pilgrim Health Care
Stride[SM] (HMO) Medicare Advantage Plan
Individual Enrollment Request Form

ENROLLMENT INSTRUCTIONS

The following steps must be completed to become a member of Harvard Pilgrim Health Care's Stride[SM] (HMO) Medicare Advantage Plan – an HMO/HMO-POS with a Medicare Contract. Enrollment in Stride[SM] (HMO) depends on contract renewal.

1. Please fill out the entire form legibly and accurately. Your Medicare information must be filled out exactly as it appears on your Medicare card
2. Be sure to read each item carefully so that you fully understand the information
3. You must sign and date the enrollment form
4. Keep the yellow copy of the enrollment form for your records

Ways to enroll:

- Call **(855) 243-1145 TTY: 711** to enroll over the phone
- Enroll online at kit.hpforlife.org
- Fill out this paper enrollment application and return it to:

  Harvard Pilgrim Health Care
  PO Box 152108
  Tampa, FL 33684-2108

Medicare beneficiaries may also enroll through the CMS Medicare Online Enrollment Center located at http://Medicare.gov

Member Services: **(888) 609-0692**
TTY: **711**
Hours of operations:
October 1 – March 31, 8 a.m. - 8 p.m. 7 days a week
April 1 – September 30, 8 a.m. - 8 p.m. Monday - Friday

Please note that Harvard Pilgrim Health Care cannot consider this application "complete" until your eligibility for Medicare Part A and enrollment in Medicare Part B has been confirmed. Please contact Harvard Pilgrim if you need information in another language or accessible format.

Please print

AGENT USE ONLY

Name of Staff Member/Agent/Broker (If assisted in enrollment)/Signature

_____ / _____

Agent Received Date

____/_____/_____

Election Type (circle) ICEP/IEP AEP MA OEP SEP (Type)_____ Not Eligible

County _____ Plan ID# _____

Agency of Agent _____ Current Insurance _____

Agent Name (First) _____ (Last) _____

Agent NPN _____ Date Received _____/_____/_____ Member ID # _____

To Enroll in Stride℠ (HMO), Please Provide the Following Information

Please check which plan you want to enroll in: **Effective Date** _____/_____/_____

STATE		PLANS AVAILABLE	MONTHLY PREMIUM	AVAILABLE IN THE FOLLOWING COUNTIES
Massachusetts	❒	Stride℠ (HMO) Basic Rx (HMO)	$0	Barnstable, Bristol, Essex, Middlesex (excludes zip codes 01824, 01826, 01863), Norfolk, Plymouth, Suffolk & Worcester
	❒	Stride℠ (HMO) Value Rx (HMO)	$67	Barnstable, Bristol, Essex, Middlesex (excludes zip codes 01824, 01826, 01863), Norfolk, Plymouth, & Suffolk
	❒	Stride℠ (HMO) Value Rx Plus (HMO)	$168	Barnstable, Bristol, Essex, Middlesex (excludes zip codes 01824, 01826, 01863), Norfolk, Plymouth, & Suffolk
	❒	Stride℠ (HMO) Value Rx (HMO)	$79	Worcester
	❒	Stride℠ (HMO) Value Rx Plus (HMO)	$195	Worcester
Maine	❒	Stride℠ (HMO) Basic Rx (HMO)	$0	Androscoggin, Cumberland, Franklin, Kennebec, Sagadahoc Knox, York, & Waldo
	❒	Stride℠ (HMO) Value Rx (HMO)	$24	
	❒	Stride℠ (HMO) Choice Rx (HMO-POS)	$34	
New Hampshire	❒	Stride℠ (HMO) Basic Rx (HMO)	$0	Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough Merrimack, Rockingham, Strafford, & Sullivan
	❒	Stride℠ (HMO) Value Rx (HMO)	$44	Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough Merrimack, Rockingham, & Sullivan
	❒	Stride℠ (HMO) Value Rx (HMO)	$49	Strafford
	❒	Stride℠ (HMO) Choice Rx (HMO-POS)	$54	Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough Merrimack, Rockingham, & Sullivan
	❒	Stride℠ (HMO) Choice Rx (HMO-POS)	$59	Strafford
	❒	Stride℠ (HMO) Value Rx Plus (HMO)	$123	Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough Merrimack, Rockingham, & Sullivan
	❒	Stride℠ (HMO) Value Rx Plus (HMO)	$128	Strafford
	❒	Stride℠ (HMO) Gain Rx℠ (HMO)	$0 – $29.70*	Cheshire, Coos, Hillsborough Merrimack, & Rockingham

*The amount you pay will vary depending on whether you receive Extra Help from Medicare for prescription drug coverage. If you are enrolled in a State Medicare Savings Program, you may automatically qualify for Extra Help.

LAST Name _____ FIRST Name _____ MI ____ ❒ Mr. ❒ Mrs. ❒ Ms.

Birth Date ____/____/____ (MM DD YYYY) Email Address (optional) _____ Sex ❒ M ❒ F

Home Phone Number ( ) _____ Alternate Phone Number (optional) ( ) _____

Permanent Residence Street Address (P.O. Box is not allowed)

Street Number _____ Street Name _____ Lot/Apartment _____

City _____ State _____ ZIP Code _____

Mailing Address (only if different from your Permanent Residence Address):

Street Number _____ Street Name _____ Lot/Apartment _____

City _____ State _____ ZIP Code _____

Emergency contact: (optional)

First Name _____ Last Name _____ MI ____

Phone Number ( ) _____ Relationship to you _____

Please Provide Your Medicare Insurance Information

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

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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 Advantage plan.

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. **You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail or Electronic Funds Transfer (EFT) each month.** You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Harvard Pilgrim Health Care the Part D-IRMAA. People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at (800) 772-1213. TTY users should call (800) 325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please select a premium payment option:
If you don't select a payment option, you will get a bill each month –(does not apply to $0 premium).

❒ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from:

❒ Social Security ❒ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums).

❒ Get a monthly bill

❒ Electronic funds transfer (EFT) from your bank account each month (see voided check below)

Note: It may up to two months for your premium payment option to take effect. You will be responsible for any premiums up to that point.

Please enclose a VOIDED check or provide the following:

Account holder name: _____

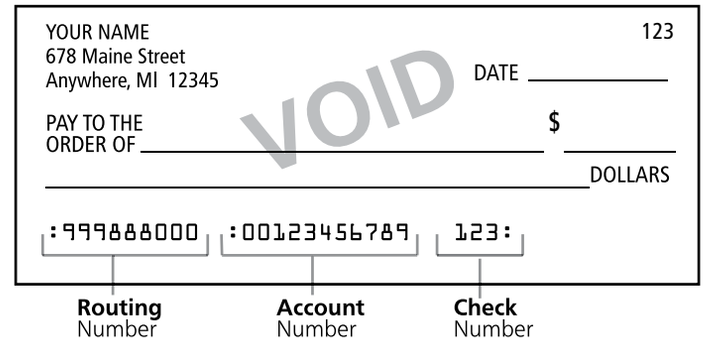
Bank routing number: _____

Bank account number: _____

Account type:

❒ Checking

❒ Savings



Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ❑ YES ❑ NO

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to **Stride℠ (HMO)**? ❑ YES ❑ NO

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage	ID # for this coverage	Group # for this coverage

3. Are you a resident in a long-term care facility, such as a nursing home? ❑ YES ❑ NO

If "yes", please provide the following information:

Name of Institution:	Phone Number:	Address: (Number and Street)

4. Are you enrolled in your State Medicaid program? ❑ YES ❑ NO

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ❑ YES ❑ NO

Please choose the NAME of a Primary Care Physician (PCP):

FIRST Name:	MI:	LAST Name:

PCP ID Number: _____

Are you an existing patient of this PCP? ❑ YES ❑ NO

Please check the box if you would prefer us to send you information in Large Print ❑ YES ❑ NO

Please contact **Stride℠ (HMO)** at (888) 609-0692 if you need information in another accessible format or language. Our office hours are October 1 to March 31, from 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30 from 8 a.m. to 8 p.m. Monday through Friday. TTY users should call 711.

STOP Please Read This Important Information for MA-PD Plans STOP

If you currently have health coverage from an employer or union, joining Stride℠ (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Stride℠ (HMO). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Stride℠ (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Stride℠ (HMO) serves a specific service area. If I move out of the area that **Stride℠ (HMO)** serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of **Stride℠ (HMO)**, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from **Stride℠ (HMO)** when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date **Stride℠ (HMO)** coverage begins, I must get all of my health care from **Stride℠ (HMO)**, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by **Stride℠ (HMO)** and other services contained in my **Stride℠ (HMO)** Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Stride℠ (HMO) WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Harvard Pilgrim Health Care, he/she may be paid based on my enrollment in **Stride℠ (HMO)**.

Release of Information: By joining this Medicare health plan, I acknowledge that Harvard Pilgrim Health Care will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Harvard Pilgrim Health Care will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature _____ Today's Date _____/_____/_____ (M M D D Y Y Y Y)

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone Number (_____) _____ Relationship to Enrollee: _____

Harvard Pilgrim Health Care

Information to Include with Enrollment Mechanism

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ❑ I am new to Medicare.
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) with an effective date of (insert date)_____
- ❑ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____
- ❑ I recently was released from incarceration. I was released on (insert date)_____
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____
- ❑ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____
- ❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____
- ❑ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)_____
- ❑ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____
- ❑ I recently left a PACE program on (insert date)_____
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____
- ❑ I am leaving employer or union coverage on (insert date)_____
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)_____
- ❑ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Harvard Pilgrim Health Care at (877) 431-4742 (TTY: 711) to see if you are eligible to enroll. We are open Oct.1 to March 31, from 8am - 8pm, Mon.- Fri, April 1 to Sept. 30, 8am - 8pm, 7 days a week.

AGENT USE ONLY

Enrollee's LAST Name: _____ **FIRST Name:**_____

Application # _____

Medicare Claim #_____ **Effective Date:**_____

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-844-299-4789 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-844-299-4789 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-844-299-4789 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-299-4789（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-844-299-4789 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-299-4789 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اَللُغةِ **العربية** ، خَدَمات اَلمُساعَدة اَللُغَوية مُتَوفرة لك مَجاناً. **إتصل على 1 -844-299-4789** (TTY: 711 **)**

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-844-299-4789 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-299-4789 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-299-4789 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-299-4789 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-844-299-4789 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-299-4789 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-844-299-4789 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-844-299-4789 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-299-4789 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-299-4789 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Harvard Pilgrim Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Harvard Pilgrim Health Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that Harvard Pilgrim Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.