

# 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.   |  |
| FIRST               |  | MIDDLE    |  | LAST   |  |
| MAILING ADDRESS     |  | COUNTY    |  | SOCIAL SECURITY #  |  |
| HOME ADDRESS        |  | COUNTY    |  | DATE OF BIRTH  |  |
| NO. STREET/P.O. BOX |  | APT #     |  | MO/ DAY/ YR/   |  |
| NO. STREET/P.O. BOX |  | APT #     |  | SEX  |  |
| CITY                |  | STATE     |  | M <input type="checkbox"/>   |  |
| CITY                |  | STATE     |  | F <input type="checkbox"/>   |  |
| CITY                |  | STATE     |  | ARE YOU CURRENTLY A HARVARD PILGRIM HEALTH CARE MEMBER?  |  |
| CITY                |  | STATE     |  | <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES LIST ID # BELOW: _____ ID # _____   |  |
| CITY                |  | STATE     |  | ARE YOU CURRENTLY A RESIDENT OF A NURSING HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME & ADDRESS OF NURSING HOME AND ADMIT DATE BELOW: _____                                 |  |
| CITY                |  | STATE     |  | WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? <b>PLEASE CIRCLE</b> ← THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.   |  |
| CITY                |  | STATE     |  | ASL American Sign Language CA Cantonese CV Cape Verdean EN English FR French HA Haitian HM Himong IT Italian KH Khmer LO Lao Lactian MN Mandarin MN Portuguese PT Portuguese RU Russian SP Spanish VI Vietnamese |  |
| CITY                |  | STATE     |  | ADDRESS ADMIT DATE / /<br>EMPLOYER PHONE # DATE OF RETIREMENT (IF APPLICABLE) / /<br>DATE OF DISABILITY (IF APPLICABLE) / /  |  |

## A COPY OF YOUR MEDICARE CARD MUST ACCOMPANY THIS FORM IN ORDER TO PROCESS YOUR ENROLLMENT.

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 \_\_\_\_\_ 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.

9/02 001-11ME EMPLOYEE SIGNATURE \_\_\_\_\_ EMPLOYER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ DATE \_\_\_\_\_

WHITE - MEDICARE ENHANCE COPY YELLOW - EMPLOYER COPY PINK - SUBSCRIBER COPY