

HPHC Insurance Company

Medicare Enhance

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

CHECK ONE		
<input type="checkbox"/>	ENROLLMENT	_____ (REASON FOR ENROLLING) _____ EFFECTIVE DATE _____
<input type="checkbox"/>	TERMINATION	_____ (REASON FOR TERMINATION) _____ LAST DAY OF COVERAGE _____
<input type="checkbox"/>	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						
HOME ADDRESS		NO. STREET/P.O. BOX		CITY		STATE		ZIP		APT #	COUNTY						
DATE OF BIRTH		MO/		DAY/		YR/		SEX		M <input type="checkbox"/>	F <input type="checkbox"/>						
LANGUAGE CODES	WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE CIRCLE ← THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.																
	ASL	CA	CV	EN	FR	HA	HM	IT	KH	LO	MN	PT	RU	SP	VI	OTHER <input type="checkbox"/>	Specify _____
	American Sign Language	Cantonese	Cape Verdean	English	French	Haitian	Hmong	Italian	Khmer	Laotian	Mandarin	Portuguese	Russian	Spanish	Vietnamese		
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:										ARE YOU CURRENTLY A HARVARD PILGRIM HEALTH CARE MEMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO							
NAME			ADDRESS			ADMIT DATE			/ /								
FORMER/CURRENT EMPLOYER			EMPLOYER PHONE #			DATE OF RETIREMENT (IF APPLICABLE)			/ /								
						DATE OF DISABILITY (IF APPLICABLE)			/ /								
										IF YES LIST ID # BELOW: ID #							

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 _____

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.

9/02 001-11ME
EMPLOYEE SIGNATURE
WHITE - MEDICARE ENHANCE COPY

DATE
YELLOW - EMPLOYER COPY

EMPLOYER SIGNATURE
DATE
PINK - SUBSCRIBER COPY