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.
H P E		

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	SEX
							MO/ DAY/ YR/	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	CA	CV	EN	FR	HA	HM	IT	KH	LO	MN	PT	RU	SP	VI	OTHER
American Sign Language	Cantonese	Cape Verdean	English	French	Haitian	Hmong	Italian	Khmer	Laotian	Mandarin	Portuguese	Russian	Spanish	Vietnamese	Specify

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) / /

ARE YOUR CURRENTLY A HARVARD PILGRIM HEALTH CARE MEMBER?

☐ YES ☐ NO

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.

EMPLOYEE SIGNATURE DATE EMPLOYER SIGNATURE DATE