

# 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	
MAILING ADDRESS		NO. STREET/P.O. BOX		CITY STATE ZIP APT # COUNTY	
HOME ADDRESS		NO. STREET/P.O. BOX		CITY STATE ZIP APT # COUNTY	
LANGUAGE CODES		WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? → PLEASE CIRCLE ← THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.		ARE YOU CURRENTLY A HARVARD PILGRIM HEALTH CARE MEMBER?	
		ASL CA CV EN FR HA HM IT KH LO MN PT RU SP VI OTHER Specify American Sign Language Cantonese Cape Verdean English French Haitian Hmong Italian Khmer Laotian Mandarin Portuguese Russian Spanish Vietnamese		□ YES □ NO	
ARE YOU CURRENTLY A RESIDENT OF A NURSING HOME? □ YES □ NO		IF YES, GIVE NAME & ADDRESS OF NURSING HOME AND ADMIT DATE BELOW:		IF YES LIST ID # BELOW:	
NAME		ADDRESS		ADMIT DATE / /	
FORMER/CURRENT EMPLOYER		EMPLOYER PHONE #		DATE OF RETIREMENT (IF APPLICABLE) / /	
				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 \_\_\_\_\_  
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