

# 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.		
<b>H P E</b>											
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	
										MO/ DAY/ YR/	
										SEX M <input type="checkbox"/> F <input type="checkbox"/>	
LANGUAGE CODES	WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? <b>PLEASE CIRCLE</b> THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.										
	<input type="checkbox"/> ASL American Sign Language <input type="checkbox"/> CA Cantonese <input type="checkbox"/> CV Cape Verdean <input type="checkbox"/> EN English <input type="checkbox"/> FR French <input type="checkbox"/> HA Haitian <input type="checkbox"/> HM Hmong <input type="checkbox"/> IT Italian <input type="checkbox"/> KH Khmer <input type="checkbox"/> LO Laotian <input type="checkbox"/> MN Mandarin <input type="checkbox"/> PT Portuguese <input type="checkbox"/> RU Russian <input type="checkbox"/> SP Spanish <input type="checkbox"/> VI Vietnamese           OTHER <input type="checkbox"/> Specify _____										
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)			/ /		
<b>A COPY OF YOUR MEDICARE CARD MUST ACCOMPANY THIS FORM IN ORDER TO PROCESS YOUR ENROLLMENT.</b>										IF YES LIST ID # BELOW:  ID # _____	

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 \_\_\_\_\_

## Medicare Part D Enrollment

### The following is **ONLY** applicable to members whose employers offer a Prescription Drug Plan (PDP) from Aetna Medicare Rx offered by SilverScript

If you enroll in Medicare Enhance from HPHC Insurance Company, Inc., you will automatically be enrolled in Aetna Medicare Rx offered by SilverScript Employer PDP, (or the “Plan”), for your prescription drug coverage. Aetna Medicare Rx offered by SilverScript is a standard Medicare Part D plan with coverage provided by your Employer. Please **read and check the box** to acknowledge that you will be enrolled in Aetna Medicare Rx offered by SilverScript.

I choose to receive prescription drug benefits from Aetna Medicare Rx offered by SilverScript, along with my enrollment in HPHC Medicare Enhance for medical coverage. My Employer will automatically enroll me in Aetna Medicare Rx offered by SilverScript prescription drug plan. I understand that I must enroll in Medicare Part A and/or Medicare Part B in order to be enrolled in Medicare Part D.

**I understand that if I am later disenrolled from Aetna Medicare Rx offered by SilverScript, I will lose both my HPHC Medicare Enhance medical coverage and my Aetna Medicare Rx offered by SilverScript coverage. If I am the retiree, I also understand that my covered spouse/dependent(s) will also lose their medical and prescription drug coverage.**

By agreeing to be enrolled in a Medicare Part D plan, I acknowledge that Aetna Medicare Rx offered by SilverScript will release my information to Medicare as necessary for treatment, payment and health care operations. I also acknowledge that the Plan will release my information, including my prescription drug data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. My personal health information will be protected as required by federal and state laws.

Aetna Medicare Rx offered by SilverScript is a Medicare drug plan and is separate from and in addition to your coverage under Medicare Part A or Part B. Your enrollment in Aetna Medicare Rx offered by SilverScript doesn’t affect your coverage under Medicare Part A or Part B. You can be enrolled in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, your enrollment in Aetna Medicare Rx offered by SilverScript will end that enrollment. It is your responsibility to inform Aetna Medicare Rx offered by SilverScript of any prescription drug coverage that you have or may get in the future.

Once you are a member of Aetna Medicare Rx offered by SilverScript, you have the right to appeal Plan decisions about payment or services if you disagree. Read the *Evidence of Coverage* document from Aetna Medicare Rx offered by SilverScript when you receive it to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

Keep in mind that if you leave the Aetna Medicare Rx offered by SilverScript plan and don’t have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare’s), you may have to pay a Part D late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

If you have any questions regarding enrollment in Aetna Medicare Rx offered by SilverScript, please feel free to contact Aetna Medicare Rx offered by SilverScript at 1-855-334-5057, 24 hours a day, 7 days a week. TTY users should call 711.