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

- **PLEASE TYPE IN SPACES PROVIDED**
- **LEAVE BLUE SHADED AREAS BLANK**
- **ATTACH A COPY OF MEDICARE CARD**

ID NUMBER	GROUP NO.	DIV. NO.
H P		

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 ☐ F ☐

LANGUAGE CODES

WHAT LANGUAGE DO *YOU* SPEAK MOST OFTEN? → **PLEASE CIRCLE** ← THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

ASL American Sign Language · CA Cantonese · CV Cape Verdean · EN English · FR French · HA Haitian · HM Hmong · IT Italian · KH Khmer · LO Laotian · MN Mandarin · PT Portuguese · RU Russian · SP Spanish · VI Vietnamese · OTHER ☐ _____ Specify

CURRENT HPHC ID# (if any):
ID # _____

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) / /

PLEASE REFER TO YOUR MEDICARE CARD:
MEDICARE NUMBER _____
PART A EFFECTIVE DATE ___ / ___ / _____
PART B EFFECTIVE DATE ___ / ___ / _____

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

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.