

# HPHC Medicare Supplement Enrollment Form

The Plan is underwritten by HPHC Insurance Company, an affiliate of  
Harvard Pilgrim Health Care of New England.

## SECTION 1.

**Plan Choice:**  Plan A    Plan F    Plan M    Plan N   Plan Effective Date \_\_\_\_\_

## SECTION 2.

### Personal Information:

First Name                      Middle Initial                      Last Name

Social Security Number

Permanent Address (*Number & Street*)

Gender    Male    Female

City/State/Zip/Code

Date of Birth    Month            Day            Year

Billing Address    (*if different from your permanent address*)

City/State/Zip Code

Telephone Number  
(    )            -

Current Insurance Carrier

Email Address

## SECTION 3.

### Medicare Information

Please take out your red, white & blue Medicare Card to complete this section.

<b>MEDICARE</b> <b>HEALTH INSURANCE</b>	
NAME _____	
MEDICARE CLAIM NUMBER _____	SEX _____
_____	
IS ENTITLED TO	EFFECTIVE DATE
<b>HOSPITAL (PART A)</b>	_____
<b>MEDICAL (PART B)</b>	_____

## SECTION 4.

### Replacement or other Coverage

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. If you were involuntarily terminated for nonpayment of premium, please also include documentation demonstrating payment of outstanding premium.

**SECTION 4. continued**

**Please Answer All Questions** [Please check Yes or No]

To the best of your knowledge,

1. (a) Did you turn age 65 in the last six months?  Yes  No  
(b) Did you enroll in Medicare Part B in the last six months?  Yes  No  
(c) If yes, what is the effective date? \_\_\_\_\_
  
2. Are you covered for medical assistance through the state Medicaid program?  
[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]  Yes  No  
If yes,  
(a) Will Medicaid pay your premiums for this Medicare supplement policy?  Yes  No  
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  Yes  No
  
3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below.  
If you are still covered under this plan, leave "END" blank.  
  
START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_  
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?  Yes  No  
(c) Was this your first time in this type of Medicare plan?  Yes  No  
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?  Yes  No
  
4. (a) Do you have another Medicare supplement policy in force?  Yes  No  
(b) If so, with what company, and what plan do you have? \_\_\_\_\_  
\_\_\_\_\_  
(c) If so, do you intend to replace your current Medicare supplement policy with this policy?  Yes  No
  
5. Have you had coverage under any other health insurance within the past 63 days?  Yes  No  
(For example, an employer, union, or individual plan)  
(a) If so, with what company and what kind of policy? \_\_\_\_\_  
\_\_\_\_\_  
(b) What are your dates of coverage under the other policy? START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_  
(If you are still covered under this plan, leave "END" blank.)

## SECTION 5.

**IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEE ISSUE (SEE #5 ON THE INSTRUCTION PAGE TO DETERMINE WHETHER THIS SECTION APPLIES TO YOU), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.**

If the answer to any question in this section is YES the Applicant is not eligible for coverage. This does not apply to applicants applying for Medicare supplement coverage under Plan A.

- Height \_\_\_\_\_ (feet/inches)
  - Weight \_\_\_\_\_ (pounds)
  - Are you now confined in a hospital or nursing home, or, within the past 60 days, have you been advised by a doctor to seek medical care or treatment in a hospital or in a nursing home?  Yes  No
  - Are you bedridden?  Yes  No
  - Do you require the use of a wheelchair? (if "YES," please give details)  Yes  No
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- Are you receiving kidney dialysis?  Yes  No
- Have you, due to mental or physical disability, authorized any person or institution to legally act in your behalf and take over your personal transactions?  Yes  No
- In the past 12 months, have you been advised to have surgery but surgery but it has not yet been done?  Yes  No
- In the past 12 months, have you been hospitalized three or more times?  Yes  No
- Do you routinely visit the same medical provider more than monthly for medical advice or treatment?  Yes  No
- Do you now have any of the following conditions or have you received medical advice or treatment for the following conditions within the past 12 months?
  - Cancer (except skin) or Leukemia
  - Chronic Lung Disease
  - Cirrhosis of the Liver
  - Diabetes (insulin dependent)
  - Stroke
  - Angina Pectoris, Heart Attack, Congestive Heart Failure, or Valvular Heart Disease
  - Alzheimer's Disease, memory loss or impairment, dementia or cognitive impairment
  - Parkinson's Disease
  - Multiple Sclerosis
  - Chronic Kidney Disease
  - Any form of Arthritis or Degenerative Bone Disease causing crippling, fractures, limitation of motion or requiring joint replacement

I represent that the statements made and answers given are complete and true. I have read and carefully considered all of the information on this form. I also represent that I received the "Outline of Medicare Supplement Coverage." I understand that no employer, former employer, health care provider, or private or government agency may sponsor, purchase or contribute to the cost of this Harvard Pilgrim Medicare Supplement Plan. I understand that to enroll in coverage, and for as long as I am covered, I must be entitled to Medicare Part A and enrolled in Medicare Part B. I understand that membership will become effective upon the first day of the month following acceptance by the Plan.

I authorize all of my health care providers, other health plans, and insurance companies to release all of my medical records and other information to the Plan or to Plan affiliated health care providers for the purpose of determining my coverage and administering my benefits.

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 the benefits for which I am eligible are those described in the applicable subscriber policy. I understand that HPHC's Medicare Supplement Insurance premium rates are subject to change as allowed by state law. I understand that enrollment in this plan is contingent upon payment of premium. I or my authorized representative is entitled to receive a copy of this authorization form.

X \_\_\_\_\_  
Signature of Applicant

X \_\_\_\_\_  
Date

125449  
\_\_\_\_\_  
Sales Agent ID