Instructions to help you complete your enrollment application for the HPHC Medicare Supplement Plan

Thank you for applying for membership to HPHC's Medicare Supplement plan.

There are 3 ways to enroll:
1. Enroll online.
2. Enroll over the phone with a plan representative, please call **1-877-906-HPHC (4742)**.
3. Complete a paper enrollment application.

Prior to submitting your enrollment application for processing, please take the time to complete the entire enrollment application. If the enrollment application received is incomplete, it may be returned to you for additional information.

You are eligible to apply for HPHC's Medicare Supplement plan if you meet all of the following requirements:

- Your legal residence is in the state of Massachusetts.
- You are eligible for Medicare Part A and Medicare Part B and enrolled in Medicare Part B.
- If you are under age 65 and qualify for Medicare coverage because of disability, the disability that qualifies you for Medicare is not solely End Stage Renal Disease (ESRD).
- You are eligible for Medicare Supplement 1 if you have attained age 65 before January 1, 2020 or first became eligible for Medicare before January 1, 2020.

Instructions:

1. Please choose a plan and effective date for coverage to begin (i.e. MM/01/YYYY). Your effective date begins the 1st of the month and cannot be prior to the date we receive your application.
2. Please fill in your personal information.
3. Your Medicare information: In order for your enrollment to be complete, you must copy information from your Medicare card, or attach a copy of your letter of Verification from the Social Security Administration or Railroad Retirement Board. If you don't have your Medicare information or have not been assigned a Medicare claim number at this time, call your local Social Security Office to enroll or to obtain proof of enrollment.
4. Read and answer all questions.
5. Read "Important Information" in Section 5.
6. Sign and date the enrollment application.

Detach the yellow copy of this application for your legal records and mail the white enrollment application to:

Harvard Pilgrim Health Care
Medicare Supplement Plan
1 Wellness Way, Canton, MA 02021

If you need assistance or have questions, please call us at:
Prospective Members: 1-877-909-HPHC (4742), TTY 711
Current Members: 1-877-907-HPHC (4742), TTY 711

Massachusetts
❒ New Enrollment
❒ Change to Enrollment

HPHC Medicare Supplement Enrollment Application

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

SECTION 1.
Plan Choice: ❒ Core Plan ❒ Supplement 1 Plan ❒ Supplement 1A Plan Plan Effective Date ____________

SECTION 2.
Personal Information:

First Name Middle Initial Last Name

Permanent Address *(Number & Street)*

City/State/Zip Code

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

City/State/Zip Code

Current Insurance Carrier

Social Security Number

___ __ ___ __ ___

Gender ❒ Male ❒ Female

Date of Birth Month Day Year

___ ___ ___

Telephone Number
( ) -

Email Address

SECTION 3.
Medicare Information
Please take out your red, white & blue Medicare Card to complete this section.

Name (as it appears on your Medicare card):

Medicare Number: ____________

Is Entitled To: Effective Date:

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

You must have Medicare Part A and Part B to join a Medicare Supplement plan.

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 premiums.

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. If you are age 65 skip this question and continue to question #3. If you are not yet age 65 you may be eligible if you can answer "No" to the following question: Are you eligible for coverage under Medicare due solely to End Stage Renal disease? ❒ Yes ❒ No

3. 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 Insurance Policy? ❒ Yes ❒ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments Toward your Medicare Part B premium? ❒ Yes ❒ No

4. (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 Insurance Policy? ❒ Yes ❒ No
   (c) Was this your first time in this type of Medicare plan? ❒ Yes ❒ No
   (d) Did you drop a Medicare Supplement Insurance Policy to enroll in the Medicare plan? ❒ Yes ❒ No

5. (a) Do you have another Medicare Supplement Insurance 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 Insurance Policy with this policy? ❒ Yes ❒ No

6. 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.

IMPORTANT INFORMATION

A. You do not need more than one Medicare Supplement Insurance Policy.

B. If you newly enroll in a Medicare Supplement 1 plan, you are not permitted to switch within the same company into a Medicare Supplement 1A plan until you have been covered by the company's Medicare Supplement 1 plan for a period of at least a 12-month period.

C. If you purchase this Policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

D. You may be eligible for Medicaid benefits and may not need a Medicare Supplement Insurance Policy.

E. The benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested,during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your Policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

   If the Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted Policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

F. If you are eligible for, and have enrolled in a Medicare Supplement Insurance Policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement Insurance Policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement Insurance Policy (or, if that is no longer available, a substantially equivalent Policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

   If the Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted Policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

G. Counseling services are available in Massachusetts to provide advice concerning your purchase of Medicare Supplement Insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program at **1-800-243-4636** (**TTY 1-800-439-2370**) or write to that office at the following address for more information: One Ashburton Place, 5th Floor, Boston, MA 02108.

SECTION 6.

I or my authorized representative certify that the statements made and answers given are complete and true. I or my authorized representative have read and carefully considered all of the information on this application. I or my authorized representative also certify that I received the "Outline of Medicare Supplement Coverage." I or my authorized representative 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 or my authorized representative 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 or my authorized representative understand that membership will become effective upon the first day of the month following acceptance by the Plan.

I or my authorized representative 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 or my authorized representative 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 or my authorized representative understand that the benefits for which I am eligible are those described in the applicable subscriber policy. I or my authorized representative understand that HPHC's Medicare Supplement Insurance premium rates are subject to change as allowed by state law. I or my authorized representative 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.

____ _______________

Signature of Applicant or Authorized Representative (if applicable)* Date

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).

SECTION 7.

NOTE: THIS SECTION IS ONLY TO BE COMPLETED IF YOU ARE WORKING WITH AN INDEPENDENT INSURANCE AGENT. PLEASE FAX ENROLLMENT FORM TO 1-617-509-4262.

I, or my authorized representative, acknowledge receipt of "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" at the time of my application for coverage in Harvard Pilgrim Health Care's Medicare Supplement Plan.

Please Print:

Applicant Name: ______________________________

Applicant Address: ______________________________

____

Medicare Number : ____________________

______________________________ ____________

Signature of Applicant, or Authorized Representative (if applicable)* Date

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).

Please Print:

Agent/Broker Name ______________________________

Agent /Broker ID ______________________________

______________________________ ____________

Agent /Broker Signature Date

SECTION 8.

NOTE: THIS SECTION IS ONLY TO BE COMPLETED IF YOU ARE WORKING WITH AN INDEPENDENT INSURANCE AGENT AND ARE REPLACING AN EXISTING MEDICARE PLAN

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

HPHC Insurance Company

1 Wellness Way, Canton, MA 02021

Save this Notice! It May be Important to you in the future.

According to the information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by HPHC Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You have 30 days to review your policy and decide whether to keep it. Except that if you are newly enrolling in a Medicare Supplement 1 Plan, then you are not permitted to switch within the same company into a Medicare Supplement 1A plan until you have been covered by the company's Medicare Supplement 1 plan for a period of at least 12 months. You should review your new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, INSURANCE PRODUCER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ❐ Additional benefits
- ❐ Fewer benefits and lower premiums
- ❐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ❐ Other (please specify) ____________________
- ❐ No change in benefits, but lower premiums
- ❐ Disenrollment from a Medicare Advantage plan.
  Please explain reason for disenrollment. Optional only for Direct Mailers ____________________
  ____

State law provides that your replacement Policy may not contain any preexisting conditions, waiting periods, elimination periods or probationary periods.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

continued

SECTION 8. continued

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it. If you cancel your present Policy and then decide that you do not want to keep your new Policy, it may not be possible to get back the coverage of the present Policy.

____

Signature of Agent, Broker, or Other Representative*

____

Typed Name and Address of Issuer, Agent, or Broker

Please Print:
Applicant Name ________________________________

Applicant Address ________________________________

____

____

________________________________ ________________

Signature of Applicant or Authorized Representative (if applicable)* Date

* If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).