



PLEASE READ THIS IMPORTANT INFORMATION

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in Humana.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay for all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

By completing this enrollment application, I agree to the following:

The Humana Group Medicare PDP is a Medicare drug plan that has a contract with the Federal government and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I can only be in one Medicare prescription drug plan at a time and if I am currently in a Medicare prescription drug plan, my enrollment in Humana Group Medicare PDP will end that enrollment. Enrollment in this plan is generally for the entire year. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Original Medicare or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify the plans so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare drug plan. I understand that I must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when I cannot reasonably use Humana network pharmacies.

I understand that I am enrolling into a Humana Medicare Advantage Plan or a Humana Medicare Prescription Drug Plan and not a Medicare Supplement, Medigap, Medicare Select, or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Humana will release my information to Medicare and other plans as necessary for treatment, payment and healthcare operations. I also acknowledge that Humana will release my information (including my prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Humana the Part D-IRMAA.

Signature:

Today's Date:

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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			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? → PLEASE CIRCLE ← 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:										
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 <input type="checkbox"/> NO <input type="checkbox"/>										
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 <input type="checkbox"/> NO <input type="checkbox"/>										
ARE YOU COVERED BY MEDICAID? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, MEDICAID NUMBER _____										
ARE YOU CURRENTLY A MEMBER OF ANOTHER MEDICAL INSURANCE PLAN (EXCLUDING MEDICARE)? YES <input type="checkbox"/> NO <input type="checkbox"/>										
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.