One Monarch Place · Suite 1500
Springfield, MA 01144-1500
1-413-787-0010 · 1-877-443-3314
TTY/TDD 1-800-439-2370

EMPLOYER/UNION GROUP HEALTH PLAN
ENROLLMENT REQUEST FORM

To Enroll in an HNE Medicare Advantage Plan, Please Provide the Following Information

Employer or Union Name: | Group #:

LAST Name: | FIRST Name: | Middle Initial | ❒ Mr. ❒ Mrs. ❒ Ms.

Birth Date: (____ / ____ / ______) (M M / D D / Y Y Y Y | Sex: ❒ M ❒ F | Social Security Number: *Providing this information is optional* | Home Phone Number: (   )

Permanent Residence Street Address:

City: | State: | ZIP Code:

Mailing Adress *(only if different from your Permanent Residence Address):*

Street Address: | City: | State: | ZIP Code:

E-mail Address:

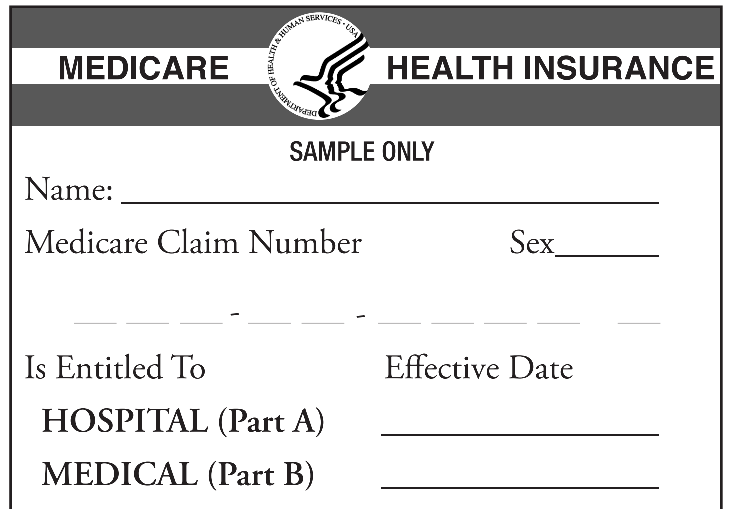
Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.
  You must have Medicare Part A and Part B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE
SAMPLE ONLY
Name: ______________________
Medicare Claim Number Sex______
___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___
Is Entitled To Effective Date
HOSPITAL (Part A) ______________
MEDICAL (Part B) ______________

Please read and answer these important questions:

1. Are you the retiree? ❒ Yes ❒ No
   If yes, retirement date: (month/date/year):______________________
   If no, name of retiree: ______________________
2. Are you covering a spouse or dependents under this employer or union plan? ❒ Yes ❒ No
   If yes, name of spouse: ______________________
   Name of dependents: ______________________
3. Do you or your spouse work? ❒ Yes ❒ No

4. Do you have End Stage Renal Disease (ESRD)? ❒ Yes ❒ No
   If you answered “yes” to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

5. Some individuals may have other drug coverage, including other private insurance, Worker’s Compensation VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to an HNE Medicare Advantage Plan with Rx or Rx Enhanced? ❒ Yes ❒ No
   If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: ID # for this coverage:

   ____

6. Are you a resident in a long-term care facility, such as a nursing home? ❒ Yes ❒ No
   If “yes” please provide the following information:
   Name of Institution: Address & Phone Number of Institution (number and street):

   ____

Please choose the name of a Primary Care Physician (PCP):______________________________

PCP Provider ID # (Found in the Provider Directory): ______________________________

Please check one of the boxes below if you would prefer us to send you information in a language other than English *or in another format*:

❒ Spanish ❒ Large Print ❒ Audio

Please contact HNE Medicare Advantage at 413-787-0010 or 877-443-3314 (TTY users should call TTY/TDD 1-800-439-2370 if you need information in another format or language than what is listed above. Our office hours are 9 a.m. - 5 p.m., Monday through Friday.

Please read and sign below

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

HNE Medicare Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not 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. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: Novemeber 15 - December 31 of every year), or under certain special circumstances.

HNE Medicare Advantage Plans serve a specific service area. If I move out of the area that HNE Medicare Advantage Plans serve, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of an HNE Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HNE Medicare Advantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date HNE Medicare Advantage coverage begins, I must get all of my health care from HNE Medicare Advantage, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by HNE Medicare Advantage and other services contained in my HNE Medicare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HNE MEDICARE ADVANTAGE WILL PAY FOR THE SERVICES.**

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HNE will release my information including my prescription drug event data to Medicare (if applicable), who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual underthe laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by HNE Medicare Advantage or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: ____

Address: ____

Phone Number: ____

Relationship to Enrollee___________________________________

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):__________________________

Plan ID #:____________________________

Effective Date of Coverage: ______________

ICEP/IEP: ______ OEP: ______ AEP: ______ SEP (type): ______ Not Eligible: ______