

Important information to help you complete your Group Enrollment Form for First Seniority Freedom Membership

Thank you for applying for membership to Harvard Pilgrim's First Seniority Freedom Plan. Prior to submitting your enrollment form for processing, please take the time to complete the entire enrollment form. If the enrollment form received is incomplete, it may not be processed and may be returned to you for additional information. If you would like to enroll over the telephone with a plan representative, please call 1-800-278-1700 (Monday-Friday 8:30 a.m.-5:00 p.m. Eastern) to see if your employer group offers this option.

Please check off each box to ensure that all of the information is provided:

(please press firmly when filling out the enrollment form)

- Your full legal name as it appears on your Medicare Card
- Your social security number (optional)
- Your date of birth
- Your gender
- Your permanent residence
- Your telephone number
- Phone number for Harvard Pilgrim to contact you for verification of joining a Private Fee-for-Service plan.
- Your mailing address if different than your home address
- Your emergency contact phone number
- The employer providing coverage
- The Group # and Division # are for internal use only – Please do not fill in
- Read and answer all questions
- Your Medicare information. (In order for your enrollment form to be complete, you must either **copy** information from your Medicare card or you may attach a **copy** of your Medicare card or 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.) **We cannot call this enrollment form “completed” until you have given us this information.**

Please turn the enrollment form over and read each statement carefully and then:

- Sign and date the front of the enrollment form.
- If you require assistance completing this enrollment form, please include the authorized representative's contact information.

Detach the pink copy of this form for your records.



If you currently have health coverage from an employer or union, joining First Seniority Freedom could affect your employer or union health benefits. If you have health coverage from an employer or union, joining First Seniority Freedom may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

If you need assistance or have questions, please call us at 1-800-779-7723, TTY/TDD 1-888-259-8276

Hours of operation are: Monday through Friday 8:30 a.m. - 5:00 p.m. Eastern

Part D Prescription Drug related questions only, representatives are available: 8:00 a.m. – 8:00 p.m. Eastern 7 days a week

A. First Seniority Freedom is a Medicare Advantage plan and I will need to keep my **Part A and Part B insurance** by paying the Part B premiums and the Part A premiums, if applicable. I understand that I can be a member of only **one Medicare Advantage plan at a time**. By enrolling in First Seniority Freedom, I will automatically be disenrolled from any other Medicare Advantage plan of which I am currently a member. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a written request to Harvard Pilgrim, or by calling 1-800-Medicare (1-800-633-4227) TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week. The disenrollment will be effective on the last day of the month in which Harvard Pilgrim receives my signed written request. Until the effective date of disenrollment, I must continue to receive health care from providers that accept Harvard Pilgrim's Terms and Conditions of payment.

B. First Seniority Freedom serves a specific enrollment area. Once I am a member of First Seniority Freedom, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Benefit Handbook from First Seniority Freedom when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

C. 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.

D. I understand that a Private Fee-for-Service plan works differently than a Medicare supplement plan. My doctor, specialist or hospital must agree to accept

Harvard Pilgrim's Terms and Conditions of payment prior to providing my healthcare services, with the exception of emergencies. If my doctor, specialist or hospital does not agree to accept Harvard Pilgrim's Terms and Conditions of payment, they may not provide healthcare services to me, except in emergencies. Providers can find Harvard Pilgrim's Terms and Conditions of payment on our website at: <http://www.harvardpilgrim.org/fsft>.

E. **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 the treatment, payment and health care operations. I also acknowledge that First Seniority Freedom will release my information including prescription drug event data to Medicare, 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.

F. First Seniority Freedom will send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan or Medigap/Medicare Select Plan** until I get that approval from First Seniority Freedom.

G. I understand that as a First Seniority Freedom member I may be responsible for paying premiums and copayments. (If I am enrolled through my employer, my employer may pay the premium).

H. The First Seniority Freedom Plan offered in New Hampshire is underwritten by Harvard Pilgrim Healthcare of New England, an affiliate of Harvard Pilgrim Health Care. Coverage in all other states is underwritten by Harvard Pilgrim Health Care.

Medicare Advantage contracts between the Federal government and Harvard Pilgrim Health Care are valid for one calendar year. The benefits, premiums, copayments, and enrollment areas offered by Harvard Pilgrim Health Care are subject to change on an annual basis. Most Medicare beneficiaries can join, including those eligible on the basis of disability.

2008 GROUP ENROLLMENT FORM

Name	First	Middle	Last	Social Security # (optional)	Date of Birth	Sex	
				- -	MO DAY YR	<input type="checkbox"/> M <input type="checkbox"/> F	
Permanent Residence Address	# Street	Apt #	City	State	Zip	County	Applicant's Home Phone # ()
Mailing Address If Different	# Street	Apt #	City	State	Zip	Emergency Contact's Home Phone # ()	
Employer providing coverage				(for internal use only)			
				GROUP #		DIVISION #	
Phone number to be used to verify with the applicant that he or she has selected a Private Fee-for-Service plan. ()							

You must answer all the questions.

- 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.
- Some individuals may have other drug coverage, including other private insurance. TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to First Seniority Freedom? 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: Group # for this coverage:

Medicare Health Insurance	
Name _____	
_____ - _____ - _____ - _____	
Medicare Claim Number	
Is Entitled To	Sex <input type="checkbox"/> M <input type="checkbox"/> F Effective Date
Hospital (Part A)	_____ - _____ - _____
Medical (Part B)	_____ - _____ - _____

3. Are you enrolled in your State Medicaid program? Yes No

If yes, please provide your Medicaid number: _____

4. 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 and Phone Number of Institution (number and street): _____

5. Do you or your spouse work? Yes No

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this enrollment form means that I have read and understand the contents of this enrollment form. 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 First Seniority Freedom or by Medicare.

YOUR SIGNATURE OR DURABLE POWER OF ATTORNEY OR LEGAL GUARDIAN SIGNATURE Date

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

Name: _____

Address: _____

Phone Number: () _____ Relationship to Enrollee: _____

Sales Agent Name (Please Print) & Signature _____ Sales Agent ID# _____

Broker Name _____ Broker ID# _____

Today's Date _____

For Internal Use Only:

Initial Receipt Date _____ Effective Date of Coverage: _____ Plan ID# _____

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