

Health Plus *Elite* (HMO)

Marketing Call Center: 1 (866) 509-7999

TTY/TDD users: 1 (800) 662-1229

Monday - Friday 8am to 8pm, Saturday 9am to 5pm.

FOR 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: _____

Enrollment Form

To Enroll in Health Plus Elite, Please Provide the Following Information:

Please check which plan you want to enroll in:

***Medicare Advantage Plan \$33.30 Per Month**

***Special Needs Plan \$0 Per Month**

Last Name		First Name		Middle Initial	Mr. Mrs. Ms.
Birth Date (/ /) (MM / DD / YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number () —		Alternate Phone Number () —	
Permanent Residence Street Address		City		State	ZIP Code
Mailing Address (only if different from your Permanent Residence Address)		City		State	ZIP Code
Emergency Contact		Relationship to You		Phone Number () —	
Your 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 the Railroad Retirement Board.

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

MEDICARE			HEALTH INSURANCE	
Name		Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Medicare Claim Number		(— — —)		
Is Entitled To		Effective Date (MM/DD/YYYY)		
HOSPITAL (Part A)		(/ /)		
MEDICAL (Part B)		(/ /)		

Your Plan Premium Option

*You can pay your monthly plan premium by mail. You can also choose to pay your premium by automatic deduction from your Social Security Benefit Check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay 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.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1) Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered “yes” to this question and you don’t need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don’t need dialysis or have had a successful kidney transplant.

2) 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 Health Plus Elite? 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

3) 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)

4) Are you enrolled in your State Medicaid program? (optional) Yes No

If yes, please provide your Medicaid number

If yes, please provide your Medicaid effective date (MM/DD/YYYY) (/ /)

5) Do you or your spouse work? Yes No

6) Are you a qualified Dual Eligible Beneficiary? (example: Full Benefit Dual Eligible, Qualified Medicare Beneficiary, Specific Low Income Medicare Beneficiary, Qualified Disabled and Working Individual) Yes No

Please write the name of a Primary Care Physician (PCP)

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 Chinese Audio

Please contact Health Plus Elite at 1-866-509-7999 (TTY/TDD users should call 1-800-662-1229) if you need information in another format or language than which is listed above. Our office hours are Monday - Friday 8am to 8pm, Saturday 9am to 5pm.



PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Health Plus Elite could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Plus Elite. If you have health coverage from an employer or union, joining Health Plus Elite 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.

Please Read and Sign Below:

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

Health Plus Elite is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare 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. 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: November 15 – December 31 of every year), or under certain special circumstances.

Health Plus Elite serves a specific service area. If I move out of the area that Health Plus Elite serves, 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 Health Plus Elite, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Plus Elite when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border..

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

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

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare Prescription Drug Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Health Plus Elite will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Plus Elite 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. 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 my behalf of the individual under the laws of the State where I live) 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 Health Plus Elite or by Medicare.

Your Signature	Today's Date
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If you are the authorized representative, you must provide the following information:

Name _____

Address _____

Phone Number _____

Relationship to Enrollee _____