

# Health Plus Elite

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:**

Group No.: \_\_\_\_\_ Plan Code: \_\_\_\_\_  
 Proposed Effective Date: \_\_\_\_\_ PBP No.: \_\_\_\_\_  
 Rep Name: \_\_\_\_\_

## Enrollment Form

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

Please check which plan you want to enroll in:

\*Health Plus Elite \$27 Per Month

Last Name	First Name	Middle Initial	Mr. Mrs. Ms.
Permanent Residence Street Address		City	State ZIP Code
Mailing Address (only if different from your Permanent Residence Address)		City	State ZIP Code
Birth Date ( / / ) (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (providing this information is optional)	Home Phone Number ( ) —
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 Railroad Retirement Board.

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

<b>MEDICARE HEALTH INSURANCE</b>	
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 Check each month.

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 does not cover.

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

Please select a premium payment option:

Receive 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 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.

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 of Institution (number and street)

Phone Number of Institution

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

If yes, please provide your Medicaid number

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

5) Do you or your spouse work?  Yes  No

Name of Employer

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

Are you an existing patient of this PCP?

Yes  No

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

Spanish  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.

Are you currently enrolled in another Medicare Advantage Plan? If so, which one?



### 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. 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 Parts A and B. I can be in only one Medicare 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 receive it to know which rules I must follow in order to receive coverage with this Medicare 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 Health Plus Elite coverage begins, I must get all of my health care from Health Plus Elite, with the exception of 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 receiving assistance from a sales agent, broker, or other individual employed by or contracted with Health Plus Elite, he/she may be compensated based on my enrollment in Health Plus Elite. 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 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 behalf of the individual under the 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 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