METROPLUS MEDICARE ENROLLMENT FORM

METROPLUS MEDICARE

Please contact MetroPlus Health Plan if you need information in another language or format (Braille).

To Enroll in MetroPlus Health Plan, Please Provide the Following Information:

Please check which plan you want to enroll in:

____ MetroPlus Advantage Plan (HMO) ___ per month
____ MetroPlus Select Plan (HMO) ___ per month
____ MetroPlus Medicare Partnership in Care Plan (HMO) ___ per month
____ MetroPlus Platinum Plan (HMO) ___ per month

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
			Home Phone Number: ( )
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)		Sex: ☐ M ☐ F	
Permanent Residence Street Address (P.O. Box is not allowed):			Optional Field: Alternate Phone Number: ( )
City:		State:	ZIP Code:

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

Street Address: ____________________________ City: _______________ State: ________ ZIP Code: __________

Emergency contact: ____

Phone Number: ____________________ **Relationship to You:** ________________________________

E-mail Address: ____

Please choose a Primary Care Physician (PCP):	PCP Phone number:
______________________________________	__________________________

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 Social Security or the 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) _______________

Paying Your Plan Premium

For Platinum Members only: If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

For all other plans: You can pay your monthly plan premium by mail each month. You can also choose to pay your premium by automatic deduction from you 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 deductible, 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 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 sucessful 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 MetroPlus? ☐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 & Phone Number of Institution (number and street): ____________

   ____

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

   If yes, please provide your Medicaid number: ____________

5. Do you or your spouse work? ☐ Yes ☐ No

6. Do you have the qualifying condition? (For MetroPlus Medicare Partnership In Care Plan (HMO) enrollees only) ☐ 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 ☐ Chinese ☐ Braille

Please contact MetroPlus Health Plan at (866)-986-0356 (TTY/TDD (800)-881-2812) if you need information in another format or language than what is listed above (such as Braille, audio tape, or large print).
Our office hours are Monday-Saturday, 8 am - 8pm.

For Medicare Advantage Partnership in Care enrollees:

Who is the primary doctor you are seeing now?

Name: ______________________________

Address: ______________________________

Phone: ______________________________

Please Read This Important Information

If you currently have health coverage from an employer or union, joining MetroPlus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MetroPlus. 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 isn't any 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:

MetroPlus 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.

MetroPlus serves a specific service area. If I move out of the area that MetroPlus 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 MetroPlus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from MetroPlus when I get it to know which rules I must follow in order 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 MetroPlus coverage begins, I must get all of my health care from MetroPlus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by MetroPlus and other services contained in my MetroPlus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Without authorization, neither Medicare nor MetroPlus 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 MetroPlus, he/she may be paid based on my enrollment in MetroPlus Medicare Advantage Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that MetroPlus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MetroPlus 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 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 MetroPlus 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: ______

Marketing:

Rep code: ____________________
Site ID Code: ____________________
Event Name:
____