MEDICARE ADVANTAGE 2019 GROUP ENROLLMENT APPLICATION

If you have any questions about our plans, need help filling out this application, or need information in another format (Braille), please call (716) 635-4900 or 1-800-958-4405 toll-free (TTY 711): **October 1– March 31:** Monday–Sunday, 8 a.m.–8 p.m.; **April 1– September 30:** Monday–Friday, 8 a.m.–8 p.m.

Independent Health®

PART 1 PLEASE TELL US ABOUT YOURSELF

Employer or Union Name _____ Preferred Effective Date (MMDDYYYY) _____

Account # _____ Plan Name _____

Last Name _____ First Name _____ Initial _____

Date of Birth (month/day/year) _____ Gender ☐ M ☐ F ☐ Mr. ☐ Mrs. ☐ Ms.

Email Address (optional)* _____

**By providing your email address, you are agreeing to receive valuable email communications from Independent Health.*

PERMANENT RESIDENCE ADDRESS (P.O. BOX IS NOT ALLOWED):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Telephone (area code and number) _____

Alternate Telephone (area code and number) _____

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

PART 2 MEDICARE ELIGIBILITY INFORMATION

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

PART 3 PLEASE LIST A PRIMARY CARE PHYSICIAN (PCP) FROM THE PROVIDER DIRECTORY

Note: Required for all plans.

Physician's Last Name _____ Physician's First Name _____

Physician's Address _____ Current Patient ☐ Yes ☐ No

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal. Y0042_G985_M FYI 09102018

PART 4 **PLEASE READ AND ANSWER THESE QUESTIONS**

1. Are you the retiree? ☐ Yes ☐ No

If YES, retirement date (MM/DD/YYYY): _____

If NO, name of retiree: _____

2. Are you the spouse of the retiree? ☐ Yes ☐ No

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

If YES, name of spouse: _____

Name of dependents: _____

_____

4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits or EPIC. Will you have other prescription drug coverage in addition to the plan in which you are enrolling? ☐ 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 _____

6. Are you a resident in a long-term care facility such as a nursing home? ☐ Yes ☐ No

If YES, please list the institution's name, address, phone number and date of admission.

Name _____ Street _____ Suite # _____

City _____ State _____ Zip Code _____

Telephone (area code and number) _____ County _____ Date of Admission _____

7. Are you enrolled in your state Medicaid Program? ☐ Yes ☐ No

If YES, please provide your Medicaid number _____

8. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation or VA benefits? ☐ Yes ☐ No

If YES, what kind of insurance do you have? _____ What is the name of your insurance? _____

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

10. Please check one of the boxes below if you would prefer us to send you information in an accessible format.

☐ Large Print ☐ Braille ☐ Other _____

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan during the Annual Enrollment Period between October 15 and December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you.
By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on *(insert date)* _____.
- ☐ I recently was released from incarceration. I was released on *(insert date)* _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on *(insert date)* _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on *(insert date)* _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on *(insert date)* _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on *(insert date)* _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on *(insert date)* _____.
- ☐ I recently left a PACE program on *(insert date)* _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on *(insert date)* _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on *(insert date)* _____..
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on *(insert date)* _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Independent Health at (716) 635-4900 or 1-800-958-4405 toll-free (TTY 711): October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

PART 5 ENROLLEE AUTHORIZATION — Please read important information on the back of this application.

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 from Medicare.

Signature _____ **Today's Date** _____

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

Last Name _____ First Name _____ Initial _____

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Telephone (area code and number) _____ Relationship to Enrollee _____

OFFICE USE ONLY Name of staff member/agent/broker (if assisted in enrollment): _____
Effective Date of Coverage: _____ Location: _____
Plan ID #: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEP: _____

PLEASE READ AND SIGN ON THE PREVIOUS PAGE

By completing this enrollment application, I agree to the following:
Independent Health 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 only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. If I enroll in a plan that does not offer prescription drug coverage, and I do not obtain 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 if an enrollment period is available (example: Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.

Independent Health serves a specific service area. If I move out of the area that Independent Health 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 Independent Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Independent Health 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.

Independent Health Medicare Advantage HMO-POS and PPO plan members only: I understand that beginning on the date Independent Health's coverage begins, using services in-network can cost less than using services out-of-network, except for emergency, urgently needed services, maternity care or out-of-area renal dialysis services.

PPO Plans: Out-of-network/non-contracted providers are under no obligation to treat Independent Health members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.

Independent Health Medicare Advantage HMO plan members only: I understand that beginning on the date Independent Health coverage begins, I must get all of my health care through Independent Health, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by Independent Health and other services contained in my Independent Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR INDEPENDENT HEALTH 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 Independent Health, he/she may be paid based on my enrollment in an Independent Health Medicare Advantage plan.

Release of information By joining this Medicare Advantage health plan, I acknowledge that Independent Health will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Independent Health will release my information including my prescription drug event data (MA-PD plans only) 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.

Independent Health®