

## 2016 Medicare Advantage Enrollment Form Eastern Idaho

### Please provide your information:

First Name	Last Name	MI	Requested Effective Date
Permanent Residence Street Address ( <b>PO Box not allowed</b> )		City	State ZIP Code
Mailing Address (only if different from above)		City	State ZIP Code
Birth Date ( / / )	Phone ( )	County	Sex <input type="checkbox"/> M <input type="checkbox"/> F
For HMO and HMO-POS plans only - Primary Care Provider: First Name Last Name		Email (optional)	

### Already a PacificSource Medicare member? Please check the box below:

I have a PacificSource Medicare plan and want to change to a different PacificSource Medicare plan.

### Check the plan and dental benefits (optional) you want to enroll in for 2016:

- Explorer 10 (PPO) \$ 49/mo       Explorer Rx 9 (PPO) \$ 112/mo  
 Essentials Rx 21(HMO) \$ 91/mo  
 Optional Supplemental Dental \$ 24/mo in addition to your monthly plan premium above

### Please provide your Medicare insurance information:



Use your red, white, and blue Medicare card to complete this section. You must have **Medicare Part A and Part B** to join a Medicare Advantage plan.

**Medicare Claim Number:** \_\_\_\_\_

### Please read and answer these important questions:

**1. Do you have End-Stage Renal Disease (ESRD)?**  YES  NO  
If "yes" and you've had a successful kidney transplant or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you had a successful kidney transplant or you don't need dialysis. Otherwise we may need to contact you to get additional information.

**2. Are you enrolled in your State Medicaid program?**  YES  NO  
If "yes" include your Medicaid number: \_\_\_\_\_

**3. Have you had other medical and/or prescription drug coverage in the last 12 months?** (i.e., other private insurance, TRICARE, Federal employee health benefits, or VA benefits).  YES  NO  
If "yes" include: Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Insurance Name: \_\_\_\_\_  
Group Name: \_\_\_\_\_ ID Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_

Will you have other **medical and/or prescription drug coverage in addition to your Medicare coverage and PacificSource Medicare?** (i.e., other private insurance, TRICARE, Federal employee health benefits, or VA benefits).  YES  NO If "yes" include: Effective Date: \_\_\_\_\_  
Termination Date: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group Name: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### For agent use only:

Agent Name (Required): \_\_\_\_\_  
Agent ID (Required): PM \_\_\_\_\_ Date Received by Agent (Required): \_\_\_\_\_

**Please confirm your eligibility for an enrollment period:**

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. If none of these statements apply to you or you're not sure, please contact Customer Service using the information in the Contact Information section.

**Please read the following carefully and check the box if the statement applies to you.** By checking any of the boxes you certify that, to the best of your knowledge, you're eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- I'm enrolling during the annual enrollment period (October 15-December 7).
- I'm new to Medicare.
- I recently moved outside the service area of my current plan or recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get Extra Help paying for Medicare prescription drug coverage effective (date) \_\_\_\_\_.
- I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on \_\_\_\_\_ (date).
- I'm moving in, live in, or recently moved out of a Long Term Care Facility (i.e., nursing home). I moved or will move in on \_\_\_\_\_ (date) or moved/will move out on \_\_\_\_\_ (date).
- I recently left a PACE program on \_\_\_\_\_ (date).
- Recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) on \_\_\_\_\_ (date).
- I'm leaving employer or union coverage on \_\_\_\_\_ (date).
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the United States. I returned to the United States on \_\_\_\_\_ (date).
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on \_\_\_\_\_ (date).
- None of the above statements apply to me. I feel I have a special circumstance which allows me an exception to enroll. Please include the reason: \_\_\_\_\_.

**Please select one of the premium payment options below:**

You can pay your monthly plan premium (optional dental benefits, and any late enrollment penalty you have or may owe) with one of the options below. *Note: If you don't select an option, we'll keep your current option or send you a bill.*

- Automatic deduction from your checking account each month. Please include a voided check.** If the account holder is different than the applicant, provide the following information:

\_\_\_\_\_   
 Account Holder Name (Print)

\_\_\_\_\_   
 Account Holder Signature

\_\_\_\_\_   
 Date

Automatic deductions are made on the 5<sup>th</sup> day of every month. Deductions include any outstanding balance on your account. If the deduction falls on a weekend or holiday, the deduction will occur the next business day. Funds can only be deducted from checking accounts. Please provide a voided check (deposit slips not accepted). You can stop deductions from your account by notifying us at the phone number or address on page 1 at least 30 days prior to the deduction date.

- Automatic deduction from your Social Security check or Railroad Retirement Board (RRB) check.** (The Social Security/RRB deduction may take two or three months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)
- Credit card.** *Once you're enrolled, we'll send you information about setting up credit card payments.*
- Get a monthly bill.**

**Please read all sections of this document before signing:**

**Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Relationship to beneficiary:  Self  Authorized Representative  Other \_\_\_\_\_

**If you are the authorized representative and you signed this form, complete the following:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

You understand your signature (or the signature of the person authorized to act on my behalf under the laws of the State where you live) on this application means you 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.

**Materials in Alternate Formats:**

Please check one of the boxes below if you would prefer us to send you information in another format:

Braille  Audio tape  Large print

Please contact Customer Service toll-free at (888) 863-3637 or TTY users call (800) 735-2900, if you need information in another format than what is listed above. Our hours are listed in the Contact Information section.

**Employer or union information:**

**If you currently have health coverage from an employer or union, joining PacificSource Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join our plan.** 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.

**Important information about paying your plan premium:**

If you have a Part D Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your monthly premium. You can either choose to have the amount withheld from your monthly Social Security check or be billed directly by Medicare or the Railroad Retirement Board (RRB). **DO NOT** pay PacificSource Medicare the Part D-IRMAA.

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 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 Social Security at (800) 772-1213. TTY users should call (800) 325-0778. You can also apply for extra help online at [www.SocialSecurity.gov/PrescriptionHelp](http://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.

**By completing this application, you agree to the following:**

We are a Medicare Advantage plan and have a contract with the Federal government. You will need to keep your Medicare Parts A and B. You can be in only one Medicare Advantage plan at a time, and you understand your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan. It is your responsibility to inform us of any prescription plan coverage you have or may get in the future.

You understand if you don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once you enroll, you may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

We serve a specific service area. If you move out of the service area, you need to notify us so you can disenroll and find a new plan in your new area. Once you are a member of our plan, you have the right to appeal plan decisions about payment or services if you disagree. You will read the Evidence of Coverage (also known as a member contract or subscriber agreement) when you get it from us to know which rules

you must follow in order to get coverage with this Medicare Advantage plan.

You understand services received outside the U.S. are not covered (except for urgent care, ambulance, emergency care, and out-of-area dialysis services).

You understand as an **Essentials (HMO) plan member** that beginning on the date your plan coverage begins, you must get all healthcare from in-network providers (these are providers we have a contract with), except for emergency, urgent care, or out-of-area dialysis services.

You understand as an **Explorer (PPO) plan member** that you have the option to receive services from either in-network or out-of-network providers. Please see your Evidence of Coverage for additional information. Beginning on the date your coverage begins, using services with in-network providers can cost less than using services with out-of-network providers, except for emergency, urgent care, or out-of-network dialysis services.

If medically necessary, we provide refunds for all covered benefits, even if you get services with out-of-network providers. Services authorized by us and other services contained in your Evidence of Coverage (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither we nor Medicare will pay for the services.**

You understand if you get assistance from a sales agent, broker or other individual employed by or contracted with us, he/she may be paid based on your enrollment in the plan.

### Release of your information:

By joining this Medicare health plan, you acknowledge PacificSource Medicare (we) will release your information to Medicare and other plans as is necessary for treatment, payment, and health care operations. You also acknowledge we will release your information including your prescription drug event data if you have a Medicare Advantage Part D plan 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 your knowledge. You understand if you intentionally provide false information on this form, you will be disenrolled from the plan.

### Contact information:

If you have questions, please contact us at:

- **(208) 433-4612 Boise**
- **(888) 863-3637 Toll-free**
- **(800) 735-2900 TTY**

Our hours are:

- October 1 to February 14: 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.
- February 15 to September 30: 8:00 a.m. to 8:00 p.m. local time zone, Monday - Friday.

**Send completed enrollment forms to us:**

**Fax:** (541) 382-4217 or (855) 382-4217 toll-free

**Email:** [medicareapplications@pacificsource.com](mailto:medicareapplications@pacificsource.com)

**Mail:** PacificSource Medicare  
PO Box 7469  
Bend, OR 97708

**Enroll Online:** [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)

PacificSource Community Health Plans is a HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. Y0021\_EN3167\_Final EI\_CMS Approved 08242015