selecthealth ADVANTAGE
P.O. Box 30196, Salt Lake City, UT 84130-0196 • Fax: 801-442-0357
selecthealthadvantage.org

SELECTHEALTH ADVANTAGE ENROLLMENT REQUEST FORM

Please contact SelectHealth if you need information in another language or format.

Effective Date of Coverage _____ / 01 / 2016

To enroll in SelectHealth Advantage (HMO), please provide the following information:

Please indicate your primary area of residence by checking the appropriate box

- ❑ TREASURE VALLEY $0/month (Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, and Washington counties)
- ❑ EASTERN & CENTRAL IDAHO $69/month (Bingham, Blaine, and Bonneville counties)
- ❑ MAGIC VALLEY $45/month (Cassia, Jerome, Minidoka, and Twin Falls counties)

LAST Name	FIRST Name	MIDDLE Initial	❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date	Sex:	Home Phone Number	Alternate Phone Number
_____ /_____ /_____ (MM / DD / YYYY)	❑ M ❑ F	( )	( )

Permanent Residence Street Address (P.O. Box is not allowed)

City	State	ZIP	County

Mailing Address (only if different from your Permanent Residence Address—a P.O. Box is acceptable):

Street Address City State ZIP

E-mail Address _____

Electronic Opt Out: You may elect to receive some post-enrollment materials electronically, including your Evidence of Coverage (EOC), which details your coverage under the plan, and Abridged Formulary, which provides a list of most commonly used, covered drugs and your Annual Notice of Changes document (ANOC) which details changes to the plan each year. To make this election, provide your email address above. You may change this election or request these items be mailed to you at any time by calling us. You can request other documents/materials be delivered electronically once you are a member of the plan.

Emergency Contact Name _____

Phone Number ( ) **Relationship to You**

Please provide your Medicare insurance information:

Use 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.

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

MEDICARE HEALTH INSURANCE

Name _____

Medicare Claim Number Sex _____

_____

Is Entitled To Effective Date

HOSPITAL (Part A) _____ / 01 /_____

MEDICAL (Part B) _____ / 01 /_____

Review these details and tell us how you would like to pay your monthly plan premium (if applicable):

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or *Railroad Retirement Board (RRB)* benefit check each month. If you are assessed a *Part D-Income Related Monthly Adjustment Amount (D-IRMAA)*, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay SelectHealth 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 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. 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 800-772-1213. TTY users should call 800-325-0778. You can also apply for extra help online at 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.

Please select a premium payment option: (If you don't select a payment option, you will get a monthly billing statement.)

❑ Monthly billing statement

❑ Electronic Funds Transfer (EFT) from your bank account each month (on or near the 10th day of the month). Please enclose a VOIDED check or provide the following:

Account Holder Name _____

Bank Routing Number _____ Bank Name _____

Bank Account Number _____

Account type: ❑ Checking ❑ Saving

❑ Automatic deduction from your monthly ❑ Social Security or ❑ Railroad Retirement Board (RRB) benefit check **(indicate which)**. **Note:** The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. During this time, please continue to pay your monthly mailed invoice. In some 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.

❑ Public Employee Retirement System of Idaho Payment Option (PERSI). Select which option applies to you:

❑ I am a retiree of state of Idaho/statewide schools

❑ I am requesting payment for my spouse who is enrolling on this plan

Retiree Name _____ Retiree Social Security # _____

School District _____

Please read and answer these important questions:

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

   If you have had a successful kidney transplant and/or you no longer need regular dialysis, please attach a note or records from your doctor indicating that you have had a successful kidney transplant or that you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.

2. Do you or your spouse work? ❑ Yes ❑ No

3. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

   If yes, please provide your Medicaid number _____

4. Some individuals may have other medical or prescription drug (Rx) coverage, including other private insurance, TRICARE, Federal employee health benefits program, VA benefits, or state pharmaceutical assistance programs.

   Once enrolled, I will have other medical or Rx coverage in addition to SelectHealth Advantage (check one):

   ❑ Medical ❑ Rx ❑ Both ❑ Neither

   If you checked Medical, Rx, or Both, please list your other coverage and identification (ID) number(s) for this coverage:

   Name of other coverage _____ ID # for this coverage _____ Carrier or Group ID # _____

5. Are you a resident in a long-term care facility, such as a nursing home? ❑ Yes ❑ No

   If "yes," please provide the following information about the institution:

   Name _____

   Address _____

   Phone Number _____

6. **Please write the name of your Primary Care Physician (PCP)** (selection required and must be an in-network PCP)

   PCP Name _____ **Provider ID#** _____

   (see provider listing in enrollment kit)

If you would prefer we send you information in a language other than English (e.g. Spanish) or in another format (e.g. large print), please contact Member Services at 855-442-9940 (toll free). TTY users should call 800-377-3529 or 711.

STOP — Please read this important information:

If you currently have health coverage from an employer or union, joining SelectHealth Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SelectHealth Advantage. 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 contact information, 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:

SelectHealth is an HMO plan sponsor with a Medicare contract. Enrollment in SelectHealth Advantage depends on contract renewal. 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 SelectHealth of any prescription drug coverage that I have or may obtain 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: October 15 to December 7 of every year) or under certain special circumstances.

SelectHealth Advantage serves a specific service area. If I move out of the area that SelectHealth Advantage 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 SelectHealth Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from SelectHealth Advantage 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 SelectHealth Advantage coverage begins, I must get all of my healthcare from providers who can bill SelectHealth Advantage, except for urgent or emergency services or out-of-area dialysis services. Services authorized by SelectHealth Advantage and other services contained in my SelectHealth Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization**, **NEITHER MEDICARE NOR SELECTHEALTH ADVANTAGE 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 SelectHealth, he or she may be paid based on my enrollment in SelectHealth Advantage.

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

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 _____

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.

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.

If none of these statements applies to you or if you have questions, please contact Member Services at 855-442-9940 (toll-free). TTY users should call 800-377-3529 or 711 to see if they are eligible to enroll.

- ❑ Annual Enrollment Period, October 15 through December 7
- ❑ I am new to Medicare
- ❑ 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 (date) _____
- ❑ I recently returned to the United States (U.S.) after living permanently outside of the U.S. I returned to the U.S. on (date) _____
- ❑ 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
- ❑ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (date) _____
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (e.g., a nursing home or long-term care facility). I moved/will move into/out of the facility on (date) _____
- ❑ I recently involuntarily lost my creditable prescription drug coverage (i.e., coverage as good as Medicare's). I lost my drug coverage on (date) _____
- ❑ I recently left a PACE program on (date) _____
- ❑ I am leaving employer or union coverage on (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 Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled for the SNP on (date) _____
- ❑ None of the above statements apply to me; however, I feel I have a special circumstance which allows me an exception to enroll. SelectHealth will contact you to determine if an exception can be granted

  Please include the reason below.

SelectHealth and Authorized Broker Use Only

Name of Agent/Broker (if assisted in enrollment) _____

Agent/Broker ID# _____

Date Received by Agent/Broker _____

SOA Confirmation # _____ SOA Form Attached? ❑ Yes ❑ No

Plan ID# H1994_00____ (3 - Treasure Valley, 4 - Magic Valley, 6 - Eastern & Central Idaho)

Check one: ❑ AEP ❑ ICEP/IEP ❑ SEP (see above for eligibility conditions)

Enrollment Request Form

2016

Toll-free	855-442-9940
TTY	800-377-3529 or 711
October 1 to February 14	Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.
February 15 to September 30	Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 3:00 p.m., Closed Sunday.

selecthealthadvantage.org

H1994_4158_FINAL_ID Approved

Five Easy Steps to Enroll

Follow these steps to request enrollment in SelectHealth Advantage (HMO).

1. Please read the entire Enrollment Request Form carefully to be sure you understand the information provided and what is being requested.
2. Have the following information handy:
   > Your red, white, and blue Medicare card
   > Your Medicaid ID number, if you have one
   > Insurance card(s) for any other health insurance you may have, if applicable
3. Sign and date the Enrollment Request Form.
   > This form is not complete unless signed and dated.
   > If an authorized legal representative completed the form on your behalf, he or she will need to sign the form and complete the information in the box immediately below the signature.
4. Keep the yellow member copy for your records.
5. Mail or fax pages 1-4 of the completed Enrollment Request Form to SelectHealth.
   > Please separate the pages at the perforations.
   > Place the original white pages in the enclosed, prepaid envelope; return only one completed Enrollment Request Form (all 4 pages) per envelope.
   > If faxing the form is more convenient, fax all 4 pages to 855-442-0357 (toll-free).

If you have questions, call Member Services toll-free at 855-442-9940 during the following dates and times:

> **October 1 to February 14:** Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.
> **February 15 to September 30:** Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 3:00 p.m., closed Sunday

Outside of these hours of operation, please leave a message and your call will be returned within one business day. TTY users should call 800-377-3529 or 711.

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