

To Enroll in FamilyCare Health Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

___ PremierCare Advantage Rx \$59.00 per month ___ PremierCare Choice Rx \$24.00 per month
___ PremierCare Choice \$0 per month ___ PremierCare Plus \$30.20 per month (prior to Low Income Subsidy)

Last Name: _____ First Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Birth Date: _____ Sex: M F Social Security Number: _____ - _____ - _____ Home Phone Number: _____
(M M / D D / Y Y Y Y) (providing this information is optional) (____) _____ - _____

Permanent Residence Street Address: _____

City: _____ State: _____ ZIP Code: _____

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


Street Address: _____ City: _____ State: _____ ZIP Code: _____

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.



NAME: _____ Sex M F
MEDICARE CLAIM NUMBER: _____ - _____ - _____
IS ENTITLED TO: _____ EFFECTIVE DATE (___/___/____)
HOSPITAL (Part A) _____
MEDICAL (Part B) _____

Paying Your Plan Premium

You can pay your monthly plan premium by mail or by Electronic Funds Transfer (EFT) each month. 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 monthly
- Electronic Funds Transfer (EFT) from your bank account each month. (A Quickpay form must be completed and submitted to take advantage of this option.)
- Automatic deduction from your monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA 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 FamilyCare Health Plans? 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 Date Moved In: (___/___/____)
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. *Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs?* Yes No

If No, how many months have you been without drug coverage? _____

If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit www.medicare.gov or call 1-800-MEDICARE.

Please choose the name of a Primary Care Physician (PCP): _____

Please check any that apply:

- | | |
|---|--|
| <input type="checkbox"/> I am new to Medicare. | <input type="checkbox"/> I recently "left" a PACE program. |
| <input type="checkbox"/> I recently moved outside the service area for my current plan. | <input type="checkbox"/> I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least as good as Medicare's). |
| <input type="checkbox"/> I was recently approved for extra help paying for Medicare prescription drug coverage. | <input type="checkbox"/> I am either losing coverage I had from an employer or leaving employer coverage. |

If none of the statements apply to you or if you are not sure, please contact us to see if you are eligible to enroll.



Please Read This Important Information



If you currently have health coverage from an employer or union, joining could affect your employer or union health benefits. If you have health coverage from an employer or union, joining FamilyCare Health Plans 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:

This is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to FamilyCare Health Plans or by calling 1-800-Medicare. TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week.

FamilyCare Health Plans serves a specific service area. If I move out of the area that FamilyCare Health Plans 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 FamilyCare Health Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from FamilyCare Health Plans when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the US border.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that FamilyCare Health Plans will release my information 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 FamilyCare Health Plans or by Medicare.

Your Signature: _____ Today's Date: _____

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

Name : _____ Phone Number: (____) _____ - _____

Address: _____ Relationship to Enrollee: _____

Office Use Only:

Name of staff member (if assisted in enrollment): _____ Plan ID #: _____

Effective Date of Coverage: _____ ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____