LEON MEDICAL CENTERS HEALTH PLANS by HealthSpring

Individual Enrollment Request Form

Please contact Leon Medical Centers Health Plans if you need information in another language or format (Braille).

To Enroll in Leon Cares, Please Provide the Following Information:

LAST Name:	FIRST Name:	Middle Initial:	❒ Mr. ❒ Mrs. ❒ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ❒ M ❒ F	Home Phone Number: ( )	Alternate Phone Number (Optional): ( )

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

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 (Optional)**:** _____

Please Provide Your Medicare Insurance Information

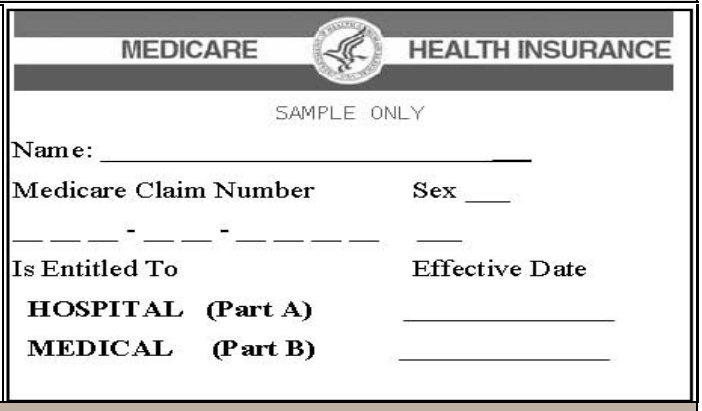
Please take out your Medicare card to complete this section.

- 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.



Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have 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.

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 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 premium payment option:

❒ Get a monthly 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 successful 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 Leon Cares? ❒ 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

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

_____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

____ Spanish **Other formats ❒ Braille ❒Large Print**

Please contact Leon Cares at 305-559-5366 (Toll-free 1-866-393-5366) if you need information in another format or language than what is listed above. Our office hours are from 8:00am – 8:00pm EST, seven days a week. TTY users should call 305-220-5752 (Toll-free 1-866-478-9317).

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Leon Cares could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Leon Cares. 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:

Leon Cares 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: October 15 – December 7 of every year), or under certain special circumstances.

Leon Cares serves a specific service area. If I move out of the area that Leon Cares 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 Leon Cares, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Leon Cares 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 Leon Cares coverage begins, I must get all of my health care from Leon Cares, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Leon Cares and other services contained in my Leon Cares Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR LEON CARES 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 Leon Cares, he/she may be paid based on my enrollment in Leon Cares.

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

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):_____

Plan ID#:__H5410-001_____ Effective Date of Coverage:_____

ICEP/IEP:_____ AEP:_____ SEP(type):_____ Not Eligible:_____

Agent/Broker ID#:_____ Agent/Broker Signature:_____ Date:_____

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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 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 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 (insert date) _____.

☐ 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.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐None of these statements applies to me.*

*Please contact Leon Medical Centers Health Plans – Leon Cares (HMO) at 305-559-5366, or toll-free at 1-866-393-5366 (TTY users should call 305-220-5752 or toll free at 1-866-487-9317) to see if you are eligible to enroll. We are open seven days a week, from 8:00 a.m. – 8:00 p.m. EST.