Please contact KelseyCare Advantage if you need information in another language or format (Braille).

To Enroll in KelseyCare Advantage, Please Provide the Following Information:

Employer or Union Name: City of Houston ______ Group #: ______

Please check which plan you want to enroll in:

❏ KelseyCare Advantage Preferred $40.87 per month

❏ KelseyCare Advantage Preferred+Choice $68.82 per month

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: (____)______-______

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: ______

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.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

NAME: ______

MEDICARE CLAIM NUMBER SEX ______

__ __ __ - __ __ - __ __ __ __ ___

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) ______

MEDICAL (PART B) ______

Please read and answer these important questions:

1. Are you the retiree? ❏ Yes ❏ No
   If yes, retirement date (month/date/year): ______
   If no, name of retiree: ______
2. Are you covering a spouse or dependents under this employer or union plan? ❏ Yes ❏ No
   If yes, name of spouse: ______
   Name of dependents: ______
3. Do you or your spouse work? ❏ Yes ❏ No
4. Do you have End-Stage Renal Disease (ESRD)? ❏ Yes ❏ No
   If you answered "yes" to this question and you don't need regular dialysis anymore, 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.

5. 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 KelseyCare Advantage? ❑ 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: ______________________

6. 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): ______________________

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 ❑ Braille ❑ Other ______________

Please contact KelseyCare Advantage at 713-442-CARE(2273) or toll-free at 1-800-663-7146 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 5 p.m., Monday-Friday. TTY users should call 1-866-302-9336.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

KelseyCare Advantage 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, or under certain special circumstances.

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

Release of Information: By joining this Medicare health plan, I acknowledge that KelseyCare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that KelseyCare Advantage 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 by KelseyCare Advantage 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 #:____________________
Effective Date of Coverage: ____________
ICEP/IEP: ______ OEP: ______ AEP: ______ SEP (type): ______ Not Eligible: ______

Agent Signature: ____________________Date: ____________Agent ID: ____________