Health Plans

Return completed form to: Enrollment Department
Indiana University Health Plans
950 N. Meridian St, Suite 200
Indianapolis, IN 46204

# Individual Enrollment Request Form

Please contact IU Health Plans if you need information in another language or format.

## To Enroll in IU Health Plans Please Provide the Following Information

**Please check which plan you want to enroll in:**

__ IU Health Medicare Select (HMO) **$0**
__ IU Health Medicare Select Plus (HMO) **$36**
__ IU Health Medicare Choice (HMOPOS) **$108**

| **FIRST** name: | **LAST** name: | Middle initial | Mr. ☐ Mrs. ☐ Ms. ☐ |
|---|---|---|---|
| Birth Date: (__ __/__ __/__ __ __ __) (M M/ D D/ Y Y Y Y) | Sex: ☐ M ☐ F | Home Phone Number: ( ) | |
| **Permanent Residence** Street Address (P. O. Box is not allowed): | | | County: |
| City: | State: | | Zip Code: |

Please choose the name of a Primary Care Physician (PCP):_____
Current Patient (circle one): Yes No Office Location: _____

(Optional) E-mail Address: _____

Mailing Address (only if different from your Permanent Residence Address):
Street Address: _____ City: _____ State: _____ Zip Code: _____
(Optional) Emergency contact (not living with you): _____
Phone Number: _____ Relationship to You: _____

## Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section —**OR**— Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

| Name | __ __ __ — __ __ — __ __ __ __ — __ Medicare Claim Number Sex: |
|---|---|
| Part A (Hospital) effective date ____/ ____/ ____ | Part B (Medical) effective date ____ / ____ / ____ |

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

## Paying Your Plan Premium

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, 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 RRB. DO NOT pay IU Health Plans 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 a late



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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 bill.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check.

Account holder name: _____

Bank Name: _____

Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving Day of Month for Withdrawal 3rd

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more 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.)

## 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 don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

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 IU 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

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

If you would prefer us to send you information in a language other than English or in another format please contact IU Health Plans Customer Solutions Center at 317-963-9700, toll-free at 1-800-455-9776 (TTY only, call Relay Indiana at 1-800-743-3333). From Oct. 1, 2013 - Feb. 14, 2014 Customer Solutions Center hours are 8:00 a.m. to 8:00 p.m. seven days a week. Beginning Feb. 15, 2014, a representative will be available from 8:00 a.m. to 8:00 p.m. Monday - Friday.

If you have questions or need assistance in completing this application please contact IU Health Plans Customer Solutions Center at the phone numbers and hours of operation listed above.

## Please Read This Important Information

**If you currently have health coverage from an employer or union, joining IU Health Plans Medicare Select Plus or IU Health Plans Medicare Choice could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join IU Health Plans Medicare Select Plus or IU Health Plans Medicare Choice. 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:**

Indiana University Health Plans is a Medicare Advantage organization with a Medicare contract. Continued enrollment depends on the contract between CMS and the Plan/Part D Sponsor remaining in effect, i.e., being renewed and not terminated. Other pharmacies/physicians/providers are avaialble in our network. Product types include HMO and HMO-POS. 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. I understand that if I don't 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. 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.

IU Health Plans serves a specific service area. If I move out of the area that IU 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 IU 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 IU Health Plans 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 IU Health Plans coverage begins, I must get all of my health care from IU Health Plans providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by IU Health Plans and other services contained in my IU Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Certain services require prior authorization. Without authorization, NEITHER MEDICARE NOR IU HEALTH PLANS WILL PAY FOR SERVICES. I can call a plan representative for assistance in determining which services require authorization.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with IU Health Plans, he/she may be paid based on my enrollment in IU Health Plans.

**Release of Information:** By joining this Medicare health plan, I acknowledge that IU Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that IU Health Plans will release my information, including any 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 _____

Office Use Only:

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

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