HealthPlus

HealthPlus MedicarePlus Group Plans

MPSERS ENROLLMENT APPLICATION

Upon completion, please send this document to:
Office of Retirement Services
PO Box 30171
Lansing, MI 48909-7671

Please Note: Each Medicare beneficiary must complete a HealthPlus MedicarePlus Group Plans Enrollment Application

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Section 1: Plan enrollment selection for employer group or union members

Employer or union name: **Michigan Public School Employee Retirement Services (MPSERS)**

Group #: **3M0307**

Please check which plan you want to enroll in:

☐ HealthPlus MedicarePlus Group Custom Plan: **Plan Code BE - MPSERS**

Section 2: Member information

Social Security Number _____

Last Name _____ First Name _____ Middle Initial _____

Permanent Street Address (PO Box is not allowed) _____

_____

City _____ State _____ Zip code _____ County _____

Home Phone Number ( ) _____ Cell Phone Number ( ) _____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Mailing Address (only if different from your permanent residence address)

Street Address _____

City _____ State _____ Zip code _____

Primary Care Physician _____ Existing Patient ☐ Yes

Section 3: Medicare card 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

Name _____ Medicare Claim # _____

Is Entitled to: Hospital (Part A) _____/_____/_____ Medical (Part B) _____/_____/_____

Section 4: Dependents

Last Name ________________________ First Name ___________________ Middle Initial ______

Primary Address (If different than member) ____

____

Social Security Number ___________________________ Date of Birth _______/_______/_______

☐ Male ☐ Female ☐ Single ☐ Married Dependent Disabled ☐ Yes

Primary Care Physician _______________________________________ Existing Patient ☐ Yes

Last Name ________________________ First Name ___________________ Middle Initial ______

Primary Address (If different than member) ____

____

Social Security Number ___________________________ Date of Birth _______/_______/_______

☐ Male ☐ Female ☐ Single ☐ Married Dependent Disabled ☐ Yes

Primary Care Physician _______________________________________ Existing Patient ☐ Yes

Last Name ________________________ First Name ___________________ Middle Initial ______

Primary Address (If different than member) ____

____

Social Security Number ___________________________ Date of Birth _______/_______/_______

☐ Male ☐ Female ☐ Single ☐ Married Dependent Disabled ☐ Yes

Primary Care Physician _______________________________________ Existing Patient ☐ Yes

Section 5: Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

   If yes, retirement date (month/day/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 ____

   Names 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 any more, or 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, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to HealthPlus? ☐ Yes ☐ No

   If yes, name of other coverage _____

   ID# for coverage _____

Your answer to the following question will not keep you from enrolling in this plan.

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 and phone number of Institution (number/street) _____

Section 6: Signature and Authorization

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

Please sign below

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 _____

Please contact HealthPlus if you need this information in another language or format (Braille):

Office hours are Monday through Friday, 8 a.m. to 6 p.m.
1-800-332-9161
TTY: 1-800-992-5070

For office use only:

If current member, please include member ID# _____

Plan ID# _____

Group name _____ Group number _____

Effective date of coverage _____

☐ ICEP/IEP ☐ AEP ☐ SEP (type) _____ ☐ Not eligible

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