HealthPlus MedicarePlus
2050 S. Linden Road
PO Box 1700
Flint, MI 48501-1700

1-800-332-9161
TDD 1-800-992-5070

HealthPlus MedicarePlus AdvantageHMO Individual Enrollment Election Form

To enroll in HealthPlus MedicarePlus, please provide the following information:

Please check which plan you want to enroll in:

☐ MedicarePlus AdvantageHMO Option 1 ☐ MedicarePlus AdvantageHMO Option 2

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: __ __ / __ __ / __ __ __ __ M M D D Y Y Y Y	Sex: ☐ M ☐ F	Social Security Number:	Home Phone Number: (__ __ __)
Permanent Residence Street Address:			
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 the Social Security Administration or Railroad Retirement Board.

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

SAMPLE ONLY

Name _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

CMS H2354_ENROLFRMB; CMS Approval 11-06-2009

Paying your Plan premium

You can pay your monthly Plan premium by mail, Electronic Funds Transfer (EFT), or 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 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 each month

☐ Electronic Funds Transfer (EFT) from your bank account each month.

Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: __ __ __ __ __ __ __ __ __

Bank account number: __ __ __ __ __ __ __ __ __ __ __ __

Account type: ☐ Checking ☐ Savings

☐ 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:

Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you answered "yes" to this question and you do not need regular dialysis anymore, 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.

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 HealthPlus MedicarePlus?
☐ 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

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 _____

Street Address of Institution: _____

Phone Number of Institution: (__ __ __) __ __ __ - __ __ __ __

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes", please provide your Medicaid number: _____

Do you or your spouse work? ☐ Yes ☐ No

Please write the name of your Primary Care Physician (PCP):

Please contact HealthPlus MedicarePlus at 1-800-332-9161 if you need information in another format or language. Our Customer Service hours are Monday through Friday, 8 a.m. to 6 p.m. TDD users should call 1-800-992-5070.

Please read this important information

If you currently have health coverage from an employer or union, joining HealthPlus MedicarePlus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthPlus MedicarePlus. Read the communications your employer or union sends you. If you have questions, visit their Web site 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:

HealthPlus MedicarePlus is a Medicare Advantage plan and has a contract with Federal government. I will need to keep my 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 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.

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: November 15 - December 31 of every year), or under certain special circumstances.

HealthPlus MedicarePlus serves a specific service area. If I move out of the area that HealthPlus MedicarePlus 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 HealthPlus MedicarePlus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Subscriber Contract from HealthPlus MedicarePlus 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 U.S. border.

I understand that beginning on the date HealthPlus MedicarePlus coverage begins, I must get all of my health care from HealthPlus MedicarePlus, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthPlus MedicarePlus and other services contained in my HealthPlus MedicarePlus Subscriber Contract will be covered. Without authorization, NEITHER MEDICARE NOR HEALTHPLUS MEDICAREPLUS WILL PAY FOR THE SERVICES.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with HealthPlus MedicarePlus, he/she may be compensated based on my enrollment in HealthPlus MedicarePlus.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

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 it necessary for treatment, payment and health care operations. I also acknowledge that HealthPlus MedicarePlus 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 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 HealthPlus MedicarePlus 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: _____