GUILDNET SM

MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Please contact GuildNet if you need information in another language or format (Braille, audiotape, large print or other).

To Enroll in GuildNet Medicare plan, Please Provide the Following Information:

Please check which plan you want to enroll in:

____ GuildNet Gold (HMO-POS) SNP ____ GuildNet Health Advantage (HMO-POS) SNP

LAST name:	FIRST Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date:	Sex:	Home Phone Number:
(__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	☐ M ☐ F	( )

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:

Contact Phone Number: ( ) - Relationship to You:

Applicant 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 the 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) _____

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 a GuildNet Medicare plan? □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 Medicaid? □ 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 (if required):

PCP Name:_____ ID # :_____

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 □ Russian □ Chinese □ Other _____

□ Braille □ Audiotape □ Large Print □ Other _____

Please contact GuildNet at 1-800-815-0000 if you need information in another format or language than what is listed above. Our office hours are Monday – Friday 8:00am – 8:00pm. TTY users should call 1-800-622-1220.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining a GuildNet Medicare plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining a GuildNet Medicare plan may change how your current coverage works. **You could lose your employer or union health coverage if you join a GuildNet Medicare plan.** 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.

By completing this enrollment application, I agree to the following: GuildNet Gold (HMO-POS) SNP/ GuildNet Health Advantage (HMO-POS) SNP is a Medicare Advantage plan and has a contract with the federal government and New York Medicaid Program. I will need to keep my Medicare Parts A and B. I can only be in 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. In order to remain enrolled in this plan, I must enroll and stay enrolled in both Medicare Advantage and Medicaid Advantage Plus. 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 voluntary and I may leave at any time by sending a request to GuildNet or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

GuildNet's Medicare plans serve a specific service area. If I move out of the area that GuildNet 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 a GuildNet Medicare plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage when I get it to know which rules I must follow to get coverage with a GuildNet Medicare 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 my GuildNet Medicare plan coverage begins, I must get my health care services as described in my GuildNet Medicare plan Evidence of Coverage. Services authorized by my GuildNet Medicare plan and other services contained in my GuildNet Medicare plan Evidence of Coverage (also known as a member contract or subscriber agreement) will be covered. Without authorization where necessary, **NEITHER MEDICARE NOR MY GUILDNET MEDICARE PLAN 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 GuildNet, he/she may be paid based on my enrollment in a GuildNet Medicare plan.

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

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

Your 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 (if assisted in enrollment):_____

Plan ID #:_____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible___