2011 Individual Enrollment Form

Enrollment Form 1

Please contact SecureHorizons® if you need information in another language or format (Audio Tape).

For Sales Representative/Agency Use Only

☐ New Member ☐ Plan Change	Employer Group ID Number	Branch ID

How was this application taken? ☐ Appointment ☐ Mail-In ☐ Other

1. Applicant Information (Please type or print in black or blue ink.)

Last Name	First Name	Middle Initial
Birth Date ____ / ____ / ____	Gender ☐ Male ☐ Female	☐ Mr. ☐ Mrs. ☐ Ms.
Home Telephone Number ( )	Alternate Phone Number (optional) ( )	

Permanent Residence Street Address (not a P.O. Box)

City	State	ZIP Code	County

Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code

E-mail Address (optional)

Please e-mail me plan information and updates.

2. 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.

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
FEMALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE Jane Doe

Name (exactly as appears on Medicare Card)

___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___
Medicare Claim Number Letter(s)

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.

3. Your Payment Options (If applicable)

If you have a plan premium AND/OR we determine that you owe a late enrollment penalty, *(or if you currently have a late enrollment penalty)*, the amount can be automatically deducted from your Social Security benefit check. The automatic deduction from your monthly Social Security benefit check may take two or more months to begin. In most cases, the first deduction will include all premiums due from your enrollment effective date up to the point withholding begins. If you don't choose this option, you can sign up for Electronic Funds Transfer (EFT). 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 Administration office, or call the Social Security Administration 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, it is recommended you choose the coupon book or EFT option.

If there is a plan premium, and/or a late enrollment penalty, deduct the total amount from my
(If you do not select a payment option, you will receive a coupon book for the amount that Medicare doesn't cover.
If you would like to set up EFT, please enclose a blank check with VOID written on the front.)

☐ **Monthly Social Security benefit check**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.
Enclose a VOIDED check or provide the following

Account Holder Name ____________________ Bank Routing Number ____________________

Bank Account Number ____________________ Account Type ☐ Checking ☐ Savings

☐ **Coupon Book**

4a. Benefit Plan Selections — Choose Only One

Health Maintenance Organization (HMO) plans with a medical and Part D drug benefit

☐ AARP® MedicareComplete® (HMO) AC
☐ AARP® MedicareComplete® Plan 1 (HMO) A1
☐ AARP® MedicareComplete® Plan 2 (HMO) A2
☐ AARP® MedicareComplete® Plan 3 (HMO) A3
☐ AARP® MedicareComplete® Value (HMO) AV
☐ AARP® MedicareComplete® Premier (HMO) APR
☐ AARP® MedicareComplete® Mosaic (HMO) AM

HMO plans with medical benefits only

☐ AARP® MedicareComplete Essential® (HMO) AE

Preferred Provider Organization (PPO) plans with a medical and Part D drug benefit

☐ AARP® MedicareComplete Choice® (PPO) ACC
☐ AARP® MedicareComplete Choice® Plan 1 (PPO) AC1
☐ AARP® MedicareComplete Choice® Plan 2 (Regional PPO) AC2
☐ AARP® MedicareComplete Choice® (Regional PPO) ACR

PPO plans with medical benefits only

☐ AARP® MedicareComplete Choice® Essential (PPO) ACE
☐ AARP® MedicareComplete Choice® Essential (Regional PPO) ACP

Point of Service (HMO-POS) plans with a medical and Part D drug benefit

☐ AARP® MedicareComplete® Plus (HMO-POS) AP
☐ AARP® MedicareComplete® Plus Plan 1 (HMO-POS) AP1

HMO-POS plans with medical benefits only

☐ AARP® MedicareComplete® Plus Essential (HMO-POS) APE

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4b. Complete the following if the plan chosen includes routine dental coverage

Name of dental provider ______________________ Provider ID# (please refer to Provider Directory) ____________

Are you currently a patient of this dentist? ☐ Yes ☐ No

4c. OPTIONAL Supplemental Benefit Plans

These plans are not available in all service areas.

Please review the Summary of Benefits to confirm availability and to learn about any applicable premiums.

If available, you can choose both the Fitness AND the Deluxe Rider (or a Dental Plan below).

☐ Fitness Rider ☐ Deluxe Rider

If available and you did not select the "Deluxe Rider" option above, you can choose ONE of the dental plans below.

☐ High Option Dental Rider ☐ Optional Dental Rider ☐ Dental 260 Rider

Dental Facility # (please refer to the Provider Directory) ______________________

☐ Dental 467 Rider ☐ Dental Platinum Rider **You do not need to select a Dental Facility for these plans.**

5. Primary Care Physician (PCP), Clinic or Health Center Selection

Refer to your Provider Directory or the plan Web site to select a PCP. Provider ID# ______________________

PCP name ______________________

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

6. Please Read and Answer These Important Questions

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

If you answered "yes" and you don't need regular dialysis any more, 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. (Use Form 2728 if available.)

If "yes", are you currently a member of a health care company? ☐ Yes ☐ No

If "yes", name of company ______________________ Member ID# ____________

Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ Yes ☐ No

If "yes", name of institution ______________________

Address of institution ______________________

City, State, ZIP Code ______________________

Telephone number of institution (____) ____________ Your date of admission to the institution ____/____/____

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

If "yes", please provide your Medicaid ID number ______________________

Do you or your spouse work? ☐ Yes ☐ No

Do you or your spouse have any health insurance other than Medicare, such as private insurance, Workers' Compensation or Veterans Administration (VA) benefits? ☐ Yes ☐ No

If you have other health insurance, what kind do you have? ______________________

What is the name of the health insurance? ______________________

Group # ______________________ ID# ______________________

Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage? ☐ Yes ☐ No

Plan name of other coverage ______________________

Member ID# for this coverage ______________________

Group ID# ______________________ Effective Date (optional) ______________________

7. Alternative Formats (Check only one)	
If available, I prefer to receive materials in the following format	☐ Spanish ☐ Chinese ☐ Large Print (English Only)

Please contact SecureHorizons® at 1-800-547-5514 if you need information in another format or language than those listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. TTY users should call 711.

Statements of Understanding

By Completing This Enrollment Form, I Agree to the Following

1. AARP® MedicareComplete® is a Medicare Advantage Plan and has a contract with the Federal Government. I must keep my Medicare Parts A and B by continuing to pay the Part B premiums and, if applicable, Part A premiums, if not otherwise paid for under Medicaid or by another third party. I can only be in one Medicare Advantage Plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in this Plan, I will automatically be disenrolled from any other Medicare Health plan or prescription drug plan of which I may be a member. It is my responsibility to inform the Plan of any prescription drug coverage that I have or may get in the future. For MA-only Plans: 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, unless Special Election Periods apply. 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, by sending a request to the Plan or by calling 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
2. I understand that I must live in the service area and if I move out of the service area, I must notify the Plan of the move. I understand that if I permanently move out of the service area, I will be disenrolled from the plan and can enroll in a plan in my new service area. 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.
3. I understand that as a member of this Plan, I have the right to appeal Plan decisions about payments or services if I disagree. I understand that I will be bound by the benefits, copayments, exclusions, limitations and other terms of the Plan. It is my responsibility to read the Evidence of Coverage when I receive it to know which rules I must follow in order to get coverage with this Medicare Advantage Plan and the amounts for which I will be responsible for payment under the Plan.
4. 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 the Plan will release my information, including my prescription drug event data if applicable, 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 Enrollment Form, I may be disenrolled from the Plan.

Statements of Understanding (continued)

By Completing This Enrollment Form, I Agree to the Following

5. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late enrollment penalty. For more information about the Late Enrollment Penalty, I may visit www.medicare.gov or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.

6. Counseling services may be available in my state to provide advice concerning Medicare Supplement Insurance or other Medicare Advantage or Prescription Drug Plan options as well as medical assistance through the state Medicaid Program and the Medicare Savings Program.

Additional Statements of Understanding for Each Specific Plan

AARP® MedicareComplete® from SecureHorizons (HMO)
I understand that beginning on the date AARP® MedicareComplete® from SecureHorizons plan coverage begins, I must receive all covered benefits from plan contracted providers and pharmacies, except for emergency or urgently needed services or out-of-area renal dialysis. I understand that authorized services and other services contained in my Evidence of Coverage document will be covered as disclosed. If I do not receive prior authorization as required for covered services, I understand that neither Medicare nor AARP® MedicareComplete® will pay for services.

AARP® MedicareComplete Choice® (PPO)
I understand that beginning on the date AARP® MedicareComplete Choice® plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the Plan provides refunds for all covered benefits, even if I get services out-of-network.

AARP® MedicareComplete® Plus (HMO-POS)
I understand that beginning on the date AARP® MedicareComplete® Plus plan coverage begins, benefits are available both in and out-of-network, and I understand I must use in-network providers to enjoy the lowest cost sharing. Some non-emergency care from non-contracted providers may not be covered at all under the Point of Service Plan. Additionally, some out-of-network services may be limited by county or state and require prior authorization.

Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Enrollment Form or files a claim containing a false or a deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

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8. Please Read This Important Information

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 Enrollment Form means that I have read, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

You must sign and date this Individual Enrollment Form in order for it to be processed.

If signed by an authorized representative of the applicant, this signature certifies the person is authorized under state law to complete this Enrollment Form and make health care decisions on behalf of the applicant and is authorized to receive health care related information on his/her behalf and that documentation of this authority is available upon request by the Plan or by Medicare. I will notify the Plan if the authority to receive health care related information changes.

Signature of applicant/member/authorized representative	Date ____ /____ /____

If you are the authorized representative of the applicant, you must provide the following information and sign above.

Name			Relationship to applicant
Address			Telephone Number ( )
City	State	ZIP Code	Alternate Phone Number (optional) ( )

9. For Sales Representative/Agency Use Only

Selling Staff Member/Agent ID	Initial Receipt Date
Selling Staff Member/Agent Name	Proposed Effective Date
Agent Telephone Number	
Signature (if assisted in enrollment)	

10. Election Period

☐ AEP ☐ ICEP ☐ IEP ☐ IEP2 (MAPD Plans Only) ☐ OEPI ☐ SEP (SEP Reason Code ____________)