


# MERCY Medicare ADVANTAGE

## ENROLLMENT APPLICATION FORM

PLEASE PRINT

A. Information About Your Medicare	B. Plan Selection	Plan Use Only
<p><i>Please fill in the blanks so they match your red, white and blue Medicare card. Attach a copy of your card.</i></p>  <p>Name: _____</p> <p>Medicare Claim Number _____ <input type="checkbox"/> Male  <input type="checkbox"/> Female</p> <p>Is Entitled To _____ Effective Date _____</p> <p>Hospital (Part A) _____/_____/_____</p> <p>Medical (Part B) _____/_____/_____</p> <p><b>You must have Medicare Part A and B to join a Medicare Advantage plan.</b></p> <p>Please check if you would prefer us to send you information in another language or format:</p> <p><input type="checkbox"/> Large Print  <input type="checkbox"/> Other Format: _____  <input type="checkbox"/> Other Language: _____</p>	<p><b>Employer Group Plan Name:</b></p> <p>_____</p> <p>_____</p> <p><b>ARKANSAS REGION</b></p> <p><input type="checkbox"/> PPO with Rx \$ _____</p> <p><b>SPRINGFIELD REGION</b></p> <p><input type="checkbox"/> HMO with Rx \$ _____</p> <p><input type="checkbox"/> HMO No Rx \$ _____</p> <p><input type="checkbox"/> PPO Silver w/Rx \$ _____</p> <p><input type="checkbox"/> PPO Gold w/Rx \$ _____</p> <p><b>ST. LOUIS REGION</b></p> <p><input type="checkbox"/> HMO with Rx \$ _____</p> <p><input type="checkbox"/> PPO with Rx \$ _____</p>	<p>_____</p> <p><b>Effective Date of Coverage</b></p> <p><input type="checkbox"/> AEP <input type="checkbox"/> OEPI</p> <p><input type="checkbox"/> ICEP/ IEP</p> <p><input type="checkbox"/> SEP (type) _____</p> <p>Prior Commercial Months:  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pt. D Creditable Coverage:  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If NO, # of Months _____</p> <p>Sales Rep # _____</p> <p>Money Order # _____</p> <p>Check # _____</p> <p>Amount \$ _____</p> <p>Cash Receipt _____</p>

C. Other Information						
Permanent Resident Street Address	Apt #	City	State	Zip	COUNTY	
Mailing Address (if different)	Apt #	City	State	Zip		
Home Phone ( )	Date of Birth			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
Alternate Phone ( )	Relationship to you			Phone number ( )		
<b>Primary Care Physician (PCP)</b> – required for Southwest Missouri HMO; requested for all other plans.						
Name of PCP:				Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly premium and/or any applicable late enrollment penalty you may owe by mail or through automatic deduction from either your bank account or your Social Security Benefit Check. **If you don't select a payment option, you will receive a bill each month.**

People with limited incomes qualify for extra help to pay for their prescriptions drug cost. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescriptions drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or late enrollment penalty.

Many people are eligible for those savings and don't even know it. For more information about this extra help, contact your Social Security Office or call Social Security at 1-800-772-1313. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://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.

**Please select a premium payment option:**

- Receive a bill each month**
- Automatic deduction from Bank Account** (Please attach VOIDED, blank check).  **Savings**  **Checking**
- Automatic deduction from Employer Pension Check** (Only available to retiree group plan members)
- Automatic deduction from 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.) *This option is not available to retiree group plan members.*

**Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.**

**Please read the following statements carefully and check the box if the statement applies to you.** By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) \_\_\_\_\_.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (i.e., a nursing home). I moved, or will move, into or out of the facility on (insert date) \_\_\_\_\_.
- I recently left a PACE program on (insert date) \_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- I lost my drug coverage on (insert date) \_\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- None of these statements applies to me.\*

\*Please contact the plan at the phone number listed on the instructions page to see if you are eligible to enroll.

**F. Please answer the following important questions:**

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

If you answered “yes” to this question 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.

2. Are you currently living in a long-term care facility, such as a nursing home?  Yes  No

Name, address and phone # of facility: \_\_\_\_\_

3. Are you enrolled in your State Medicaid program?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

4. 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 Mercy MedicareADVANTAGE?**

Yes  No

If yes, please provide the following information regarding the coverage:

Name of coverage: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

**If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer group or union health coverage if you join Mercy MedicareADVANTAGE 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 benefit administrator or office that answers questions about your coverage can help.**

**This Section for Plan Use Only**

Name and ID # of staff member, agent or broker who assisted with this enrollment:	Application Receive Date	Application Complete Date
Other information:		

**By completing this enrollment application, I agree to the following:**

This plan is a Medicare Advantage plan and has a contract with the Federal government. 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 or under certain special circumstances.

This plan serves a specific service area. If I move out of the area that this plan 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 this plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from this plan 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 my coverage begins, I must get all of my health care from the plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the plan and other services contained in my plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN WILL PAY FOR THE SERVICES.** If I selected the PPO plan, "I understand that beginning on the date 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.

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

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

I expect my effective date will be \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ unless otherwise notified.

**Signature of Applicant or Legal Representative\*:**

**Today's Date:**

\*If signed by Legal Representative, please provide the following and attach proof of authorization:

If someone else helped fill out this application, please have them sign and date below:

Name: \_\_\_\_\_

Signature  
of helper: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to enrollee: \_\_\_\_\_