

# APPLICATION INSTRUCTIONS

## How do I sign up?

**OPTION I.** You may choose to schedule an appointment with a Membership Specialist. The Membership Specialist will take the time to help you complete the enrollment application. To schedule an appointment or attend a group presentation, please call the phone numbers below.

**OPTION II.** You may choose to enroll by mail. Please complete the following application and return to us by using the postage-paid envelope provided.

### ENROLLMENT APPLICATION FORM PROCESS

- Use ballpoint pen – black or blue ink only. Please press firmly.
- Complete the Enrollment Application Form by reading and answering all questions on all four pages. You do not need to complete sections marked “Plan Use Only”.
- Sign and date the completed form.
- Keep the pink copy and return the white and yellow copies in the enclosed envelope with all of the necessary attachments/enclosures.

**OPTION III:** You may choose to enroll online by accessing our website at [www.mercyhealthplans.com](http://www.mercyhealthplans.com) or through the Medicare website at [www.Medicare.gov](http://www.Medicare.gov).

**OPTION IV:** You may choose to enroll by phone by calling us at the numbers below.

### PLEASE INCLUDE THE FOLLOWING WITH YOUR APPLICATION:

#### 1. PHOTOCOPY OF MEDICARE CARD AND OTHER INSURANCE CARD (if applicable)

- Photocopy on regular letter-size paper.
- If you are becoming Medicare eligible and your Medicare Card has not been issued, please request a “TPQY” printout or letter of Medicare eligibility from Social Security or the Railroad Retirement Board.
- Application could be delayed if proof of eligibility is not provided.

#### 2. IF ELECTING AUTOMATIC DEDUCTION THROUGH BANK WITHDRAWAL

- Send a **voided, blank check** with your application. Note: Depending upon the timing of receipt of your application, you may have to pay your first month’s premium by check.

If you have any questions regarding the enrollment form or application process, please call us:

Arkansas PPO	800-919-6459   TDD 800-468-4418
St. Louis HMO	314-214-8040 or 800-280-1602   TDD 314-214-8094 or 800-468-4418
St. Louis PPO	314-810-8300 or 800-919-6459   TDD 314-214-8094 or 800-468-4418
Springfield HMO	417-837-0200 or 800-330-8449   TDD 417-837-0249 or 800-446-1468
Springfield/Joplin PPO	417-837-0200 or 800-330-8449   TDD 417-837-0249 or 800-446-1468

Representatives are available:

November 15 - March 2: 7 days a week, 8:00 a.m. - 8:00 p.m. (Central Time)

March 3 - November 14: Monday - Friday 8:00 a.m. - 5:00 p.m. (Central Time).

Part D prescription drug calls are accepted until 8:00 p.m. After hours, you will reach our voice mail system. Please leave a message so that we may return your call the next business day.


**Thank you for choosing Mercy Health Plans!**

H2667/H2611\_6083 v13 9\_09  
Approved 10/03/09

# 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><u>Is Entitled To</u>                      <u>Effective Date</u></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</p> <p><input type="checkbox"/> Other Format: _____</p> <p><input type="checkbox"/> Other Language: _____</p>	<p><b>Employer Group Plan Name:</b></p> <p>_____</p> <p>_____</p> <p><b>Individual Plan Options:</b></p> <p><b>ARKANSAS REGION</b></p> <p><input type="checkbox"/> PPO 1 with Rx    \$ _____</p> <p><input type="checkbox"/> PPO 2 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><input type="checkbox"/> PPO Gold No Rx    \$ _____</p> <p><b>ST. LOUIS REGION</b></p> <p><input type="checkbox"/> HMO with Rx        \$ _____</p> <p><input type="checkbox"/> PPO 1 with Rx     \$ _____</p> <p><input type="checkbox"/> PPO 2 with Rx     \$ _____</p>	<p>_____</p> <p><b>Effective Date of Coverage</b></p> <p><input type="checkbox"/> AEP    <input type="checkbox"/> OEP    <input type="checkbox"/> OEPI</p> <p><input type="checkbox"/> ICEP/ IEP    <input type="checkbox"/> OEP New</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>_____</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 (        )		

**Primary Care Physician (PCP)** – required for Southwest Missouri HMO; requested for all other plans.

Name of PCP: \_\_\_\_\_ Existing Patient?    Yes    No

**D. Payment Method** (If applicable)

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.**

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your drug cost premium. If Medicare pays only a portion of this premium, we will bill you for the remaining amount. Those who qualify won't have a coverage gap or a late enrollment penalty. 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](http://www.socialsecurity.gov/prescriptionhelp).

#### D. Payment Method (Continued)

**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.*

#### E. Confirmation of Eligibility for an Enrollment Period

**Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you *don't add or drop your prescription drug coverage* (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). 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 making an allowable election during the annual or open enrollment period.
- I am new to Medicare and joining a Medicare Advantage plan for the first time.
- 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:**

(Answers to questions 2 – 5 cannot be used to deny your application for membership)

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

If so, you are not eligible for this plan unless you are currently enrolled in a Mercy commercial plan or have documentation from your doctor stating you no longer require dialysis or have had a successful kidney transplant.

**Please attach a note or records from your doctor**, if applicable.

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, FEHB 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 **yes**, will you be receiving any health/medical coverage from this employer?  Yes  No

If **yes**, does this company employ 20 or more people?  Yes  No

If **yes**, please provide the following information regarding the employer and the coverage you will be receiving:

Employer name and address: \_\_\_\_\_

Group Health Plan Name: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Termination date of coverage: \_\_\_\_\_

Type of coverage(s):  Medical  Dental  Vision  Drug/prescription  Other: \_\_\_\_\_

**STOP!!**

**PLEASE READ THIS IMPORTANT INFORMATION**

**If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining this plan may change how your current coverage works or cause you to lose your coverage completely. 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 is no information on whom to contact, your benefits administrator or the 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:		

**Please Read and Sign Below**

**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 in this plan, 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, services can be provided by in network or out of network providers. I will pay a higher cost for out of network services, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the plan provides 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: \_\_\_\_\_