2018

Group Medicare Supplement and Group PDP Combined Retiree Application

301 S. Vine St.
Urbana, IL 61801-3347
1-800-965-4022
TTY /TDD 711 or
1-800-526-0844 (Illinois Relay)

APPLICATION FOR GROUP MEDICARE SUPPLEMENT AND STAND-ALONE PDP

Member Assigned #:
Effective Date:
Group #:
Name of Group/Employer:

SECTION 1: APPLICANT(S)

Applicant A	**Applicant B**
Name *(Last, First, Middle Initial)*	Name *(Last, First, Middle Initial)*
Medicare Number *(required)* ___ ___ ___–___ ___–___ ___ ___ ___ ___	Medicare Number *(required)* ___ ___ ___–___ ___–___ ___ ___ ___ ___
Hospital Insurance (Part A) Entitlement Date *(mm/dd/yyyy)*	Hospital Insurance (Part A) Entitlement Date *(mm/dd/yyyy)*
Hospital Insurance (Part B) Entitlement Date *(mm/dd/yyyy)*	Hospital Insurance (Part B) Entitlement Date *(mm/dd/yyyy)*
Permanent Address or P.O. Box including City, State and ZIP Code	Permanent Address or P.O. Box including City, State and ZIP Code
Mailing Address including City, State and ZIP Code *(if different from above)*	Mailing Address including City, State and ZIP Code *(if different from above)*
Home Telephone	Home Telephone
Sex: ❑ Male ❑ Female — Date of Birth	Sex: ❑ Male ❑ Female — Date of Birth
Marital Status: ❑ Married ❑ Single ❑ Widowed	Marital Status: ❑ Married ❑ Single ❑ Widowed

SECTION 2: PLAN SELECTION

Select One: ❑ Plan A ❑ Plan F ❑ Plan N	Select One: ❑ Plan A ❑ Plan F ❑ Plan N

SECTION 3: CONSUMER PROTECTION INFORMATION

If you lost or are losing other health insurance coverage and received a notice from you prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please answer all questions to the best of your knowledge.	**Please answer all questions to the best of your knowledge.**
1. **Yes / No** a. Did you turn age 65 in the last six months? ❑ ❑ b. Did you enroll in Medicare Part B in the last six months? ❑ ❑ c. If Yes, what is the effective date? ___________________	1. **Yes / No** a. Did you turn age 65 in the last six months? ❑ ❑ b. Did you enroll in Medicare Part B in the last six months? ❑ ❑ c. If Yes, what is the effective date? ___________________
2. Are you covered for medical assistance through the state Medicaid program? (*Note to Applicant:* If you are participating in a "Spend-Down Program" and have not met your "Share of Cost, " please answer No to this question.) ❑ ❑ **If Yes**: a. Will Medicaid pay your premiums for this Medicare Supplement policy? ❑ ❑ b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ ❑	2. Are you covered for medical assistance through the state Medicaid program? (*Note to Applicant:* If you are participating in a "Spend-Down Program" and have not met your "Share of Cost, " please answer No to this question.) ❑ ❑ **If Yes**: a. Will Medicaid pay your premiums for this Medicare Supplement policy? ❑ ❑ b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ ❑

Yes No

3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. (If you are still covered under this plan, leave "End Date" blank)

Start Date: ________________ End Date: ________________

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ❑ ❑
(If Yes, read and fill out * section on next page)

b. Was this your first time in this type of Medicare plan? ❑ ❑

c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ❑ ❑

4. Do you have another Medicare Supplement policy in force? ❑ ❑

a. If Yes, with what company and what plan do you have?

____

____

b. If Yes, do you intend to replace your current Medicare Supplement policy with this policy? ❑ ❑
(If Yes, read and fill out * section on next page)

5. Have you had coverage under any other health insurance within the past 64 days? (For example, an employer, union or individual plan) ❑ ❑

a. If Yes, with what company, and what kind of policy?

____

____

b. What are your dates of coverage under the other policy? (If you are still covered under this policy, leave "End Date" blank.)

Start Date: ________________ End Date: ________________

I certify that (1) the statements and answers above are true, complete and correct to the best of my knowledge and belief. (2) I have read and understand the statements in this document regarding Medicare Supplement coverage. (3) I have received an Outline of Coverage and the *Guide to Health Insurance for People With Medicare*. (4) If applicable, I have read and understand the section called "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."

Applicant Signature: ______________________________________

Date: _________________

Legal Guardian Signature: _________________________________
(must provide documentation)

Date: _________________

Yes No

3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. (If you are still covered under this plan, leave "End Date" blank)

Start Date: ________________ End Date: ________________

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ❑ ❑
(If Yes, read and fill out * section on next page)

b. Was this your first time in this type of Medicare plan? ❑ ❑

c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ❑ ❑

4. Do you have another Medicare Supplement policy in force? ❑ ❑

a. If Yes, with what company and what plan do you have?

____

____

b. If Yes, do you intend to replace your current Medicare Supplement policy with this policy? ❑ ❑
(If Yes, read and fill out * section on next page)

5. Have you had coverage under any other health insurance within the past 64 days? (For example, an employer, union or individual plan) ❑ ❑

a. If Yes, with what company, and what kind of policy?

____

____

b. What are your dates of coverage under the other policy? (If you are still covered under this policy, leave "End Date" blank.)

Start Date: ________________ End Date: ________________

I certify that (1) the statements and answers above are true, complete and correct to the best of my knowledge and belief. (2) I have read and understand the statements in this document regarding Medicare Supplement coverage. (3) I have received an Outline of Coverage and the *Guide to Health Insurance for People With Medicare*. (4) If applicable, I have read and understand the section called "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."

Applicant Signature: ______________________________________

Date: _________________

Legal Guardian Signature: _________________________________
(must provide documentation)

Date: _________________

***Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to the information furnished in your application you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Health Alliance Medical Plans, Inc. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURANCE PRODUCER:
I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement or, if applicable, policy will not duplicate your existing Medicare Supplement coverage because you intend to terminate your existing Medicare Supplement or leave your Medicare Advantage Plan. The replacement policy is being purchased for the following reason (Check one and explain below):

	Additional benefits.		My plan has outpatient prescription drug coverage, and I am enrolling in Medicare Part D for disenrollment.
	No change in benefits, but lower premiums.		Fewer benefits and lower premiums.
	Disenrollment from a Medicare Advantage Plan.		Other

Please specify and/or explain:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. (Note: If the insurer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing, preexisting limitations, please skip to statement below.)

2. Section 363(7)(b) of the Illinois Insurance Code [215 ILCS 5/363(7)(b)] provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

To Be Completed By Insurance Producer:

1. List any policies personally sold to the applicant that are still in force. Indicate if policy is to be replaced. Name of Company ____________ Type of Coverage ____________ To be replaced? ❏ Yes ❏ No	1. List any policies personally sold to the applicant that are still in force. Indicate if policy is to be replaced. Name of Company ____________ Type of Coverage ____________ To be replaced? ❏ Yes ❏ No
2. List policies personally sold to the applicant in the past five (5) years that are no longer in force. Name of Company ____________ Type of Coverage ____________ Policy Number ____________	2. List policies personally sold to the applicant in the past five (5) years that are no longer in force. Name of Company ____________ Type of Coverage ____________ Policy Number ____________

To the best of my knowledge, replacement ❏ is / ❏ is not involved in the purchase. I certify that I have reviewed the current health insurance coverage of the applicant and find that additional coverage, of the type and amount applied for, is appropriate for the applicant's needs.

Insurance Producer Signature ____________

Printed Full Name of Insurance Producer ____________

Important Information Regarding Medicare Supplement Coverage

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

An individual qualifying for Medicare can enroll during their Initial Enrollment Period or if their employer group plan offers an annual open enrollment.

If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. The benefits and premiums under your Medicare Supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by another or a spouse's employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose the employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days after losing your employer or union-based group health plan.

If you are under 65 and on Medicare, but you declined a Medicare Supplement policy because you were still covered under another or a spouse's employer group health plan, you will have a 63-day Open Enrollment period if the employer plan terminates or ceases to provide health benefits that supplement Medicare. If you are currently enrolled in a Medicare Advantage plan or have a Medicare Supplement policy and the insurance company goes out of business, withdraws from the market, or misrepresented the product you purchased, you will be eligible for a 63-day Open Enrollment period.

Counseling services are available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the State Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB). For information on Medicaid eligibility, call 1-800-252-8635. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

I hereby apply for membership and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date specified on my Medicare Supplement Policy Schedule. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.

I hereby authorize and direct Health Alliance Medical Plans, Inc., (Health Alliance) and/or the plan administrator to obtain all information and medical records from any health care provider that, either before or after acceptance of my application and enrollment in the plan, advised, treated, attended or rendered service to me, or that has in their possession any information or records with respect to advice, treatment or services. This authorization is limited only to such personal information and medical records as are necessary for Health Alliance and/or the plan administrator to determine the acceptability of this application; post-enrollment claims review; treatment; coordination of care; quality improvement; measurement, including reporting activities, surveys and accreditation; medical management and reporting activities; utilization review; complaints and appeals and requests for services or benefits under the plan, or for establishment and maintenance of proper records. A copy of this authorization and release shall be as valid as the original and will remain in effect as long as I am enrolled in the plan or until rescinded by me in writing.

I authorize Health Alliance, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Centers for Medicare & Medicaid Services, or its duly appointed Part A or Part B carriers or intermediaries, to release to Health Alliance information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include Explanations of Medical Benefits (EOMBs), “deduct-not-met” or denial letters, Part B billing forms and date of entitlement to Part B of Medicare. I further authorize ongoing release of this information to Health Alliance for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Health Alliance in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, I will need to fill out claim forms, and some records could be released before the rescission takes effect.

Stand-Alone Prescription Drug Plan (PDP) Application for Applicant A

More Information, Please

The Centers for Medicare & Medicaid Services requires Health Alliance Medicare to collect and provide additional information related to our Stand-Alone Prescription Drug Plans. Please read and complete the following information.

Please select the plan you are enrolling in:
❑ PDP Option 1 ❑ PDP Option 2 ❑ Other: ______________________________

Emergency Contact: ______________________________

Phone Number: (   )   -   Relationship to You: ______________________

Email Address:

Please answer the following questions:

1. 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 Health Alliance Medicare Stand-alone Prescription Drug 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: ____________

2. 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 and phone number of institution (number and street): ______________________________

   ____

3. Are you the retiree? ❑ Yes ❑ No

   If no, name of the retiree: ______________________________

4. 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.

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format: ❑ Spanish ❑ Large print

Please contact Health Alliance Medicare at 1-800-965-4022 if you need information in another format or language than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. TTY users should call 711.

STOP — Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Health Alliance Medicare Standalone Prescription Drug Plan, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Health Alliance Medicare Standalone Prescription Drug Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Alliance Medicare Standalone Prescription Drug 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 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:

Health Alliance Medicare Standalone Prescription Drug Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Health Alliance Medicare Standalone Prescription Drug Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in Health Alliance Medicare Standalone Prescription Drug Plan will end that enrollment.

I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Health Alliance Medicare Standalone Prescription Drug Plan network pharmacies. Once I am a member of Health Alliance Medicare Standalone Prescription Drug 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 Health Alliance Medicare Standalone Prescription Drug Plan when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Health Alliance Medicare Standalone Prescription Drug Plan, he/she may be paid based on my enrollment in Health Alliance Medicare Standalone Prescription Drug Plan.

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

Release of Information:
By joining this Medicare prescription drug plan, I acknowledge that Health Alliance Medicare Standalone Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Alliance Medicare Standalone Prescription Drug 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 State law 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 Health Alliance Medicare Standalone Prescription Drug Plan 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: ____________________________

Stand-Alone Prescription Drug Plan (PDP) Application for Applicant B

More Information, Please

The Centers for Medicare & Medicaid Services requires Health Alliance Medicare to collect and provide additional information related to our Stand-Alone Prescription Drug Plans. Please read and complete the following information.

Please select the plan you are enrolling in:
❑ PDP Option 1 ❑ PDP Option 2 ❑ Other: ______________________________

Emergency Contact: ______________________________

Phone Number: ( ) - Relationship to You: ______________________

Email Address:

Please answer the following questions:

1. 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 Health Alliance Medicare Stand-alone Prescription Drug 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: ______________

2. 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 and phone number of institution (number and street): ______________________________

   ____

3. Are you the retiree? ❑ Yes ❑ No

   If no, name of the retiree: ______________________________

4. 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.

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format: ❑ Spanish ❑ Large print

Please contact Health Alliance Medicare at 1-800-965-4022 if you need information in another format or language than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. TTY users should call 711.

STOP — Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Health Alliance Medicare Standalone Prescription Drug Plan, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Health Alliance Medicare Standalone Prescription Drug Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Alliance Medicare Standalone Prescription Drug 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 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:

Health Alliance Medicare Standalone Prescription Drug Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Health Alliance Medicare Standalone Prescription Drug Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in Health Alliance Medicare Standalone Prescription Drug Plan will end that enrollment.

I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Health Alliance Medicare Standalone Prescription Drug Plan network pharmacies. Once I am a member of Health Alliance Medicare Standalone Prescription Drug 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 Health Alliance Medicare Standalone Prescription Drug Plan when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Health Alliance Medicare Standalone Prescription Drug Plan, he/she may be paid based on my enrollment in Health Alliance Medicare Standalone Prescription Drug Plan.

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

Release of Information:
By joining this Medicare prescription drug plan, I acknowledge that Health Alliance Medicare Standalone Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Alliance Medicare Standalone Prescription Drug 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 State law 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 Health Alliance Medicare Standalone Prescription Drug Plan 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: ______________________________