Health Alliance
GROUP MEDICARE PLANS℠

MEDICARE ADVANTAGE HMO AND PPO GROUP ENROLLMENT REQUEST FORM FOR IOWA

1-877-917-8550
301 S. Vine St.
Urbana, IL 61801

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID # _____ Effective Date of Coverage: _____

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

Please contact Health Alliance Medicare if you need information in another language or format.

To Enroll in Health Alliance Medicare, Please Provide the Following Information:

Desired Effective Date (must be in the future, not more than 60 days out):_____

Employer or Union name:	Group #:

Please check which plan you want to enroll in: ❑ HMO ❑ PPO

LAST name: FIRST name: Middle initial	❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date: (__ __ / __ __ / __ __ __ __) M M D D Y Y Y Y	Sex: ❑ M ❑ F	Home Phone Number: ( ) -	Alternate Phone Number: ( ) -

Permanent Residence:

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Mailing Address: *(only if different from your Permanent Residence Address)*:

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address:

Please list the name of your previous health insurance provider:

For HMO plans only:

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Please Provide Your Medicare Insurance Information:

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

Hospital (Part A) _____

Medical (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions:

1. Are you the retiree? ❑ Yes ❑ No

   If yes, retirement date (month/date/year): _____

   If no, name of the retiree: _____

2. Do you or your spouse work? ❑ Yes ❑ No

3. Do you receive any Veteran's Affairs (VA) benefits? ❑ Yes ❑ No

   If "yes," which VA Facility? _____

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

   If yes, please provide your Medicaid number: _____

5. 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.

6. 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 <u>prescription</u> drug coverage in addition to Health Alliance Medicare? ❑ 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: _____

7. 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): _____

   _____

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 1-877-917-8550 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.

Please Read and Sign on Next Page

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

Health Alliance Medicare is a Medicare Advantage plan and a Medicare drug 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 if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Health Alliance Medicare serves a specific service area. If I move out of the area that Health Alliance Medicare 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 Health Alliance Medicare, 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 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.

For HMO plans only: I understand that beginning on the date Health Alliance Medicare coverage begins, I must get all of my health care from Health Alliance Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Alliance Medicare and other services contained in my Health Alliance Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH ALLIANCE MEDICARE WILL PAY FOR THE SERVICES.**

For PPO plans only: I understand that beginning on the date Health Alliance Medicare 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, Health Alliance Medicare provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Health Alliance Medicare and other services contained in my Health Alliance Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH ALLIANCE MEDICARE WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that Health Alliance Medicare 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 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 Health Alliance Medicare 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: _____

DISCRIMINATION IS AGAINST THE LAW

Health Alliance Medicare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance Medicare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance Medicare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance Medicare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance Medicare, Member Services, 301 S. Vine Street, Urbana, IL 61801, telephone: 1-800-965-4022 TTY: 711, fax: 217-337-3425, MemberServices@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame 1-800-965-4022 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫 1-800-965-4022（TTY: 711）。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. Zadzwoń 1-800-965-4022 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-800-965-4022 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-965-4022 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. Вызов 1-800-965-4022 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag 1-800-965-4022 (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . استدعاء 1-800-965-4022 (TTY: 711).

Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. Anruf 1-800-965-4022 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez 1-800-965-4022 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કૉલ 1-800-965-4022 (TTY: 711).

注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。1-800-965-4022コール（TTY: 711）。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. Bel 1-800-965-4022 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. Виклик 1-800-965-4022 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare 1-800-965-4022 (TTY: 711).