Health Alliance NORTHWEST

MEDICARE ADVANTAGE HMO AND HMO-POS GROUP ENROLLMENT REQUEST FORM

SignalHealth

1-877-795-6117
Application Processing Center
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 mark the plan you are enrolling in:

❑ HMO Option 1	❑ POS Option 1
❑ HMO Option 2	❑ POS Option 2
❑ SignalAdvantage HMO	❑ SignalAdvantage POS
❑ SignalAdvantage HMO Rx	❑ SignalAdvantage POS Rx
❑ SignalAdvantage HMO Rx Plus	❑ SignalAdvantage POS Rx Plus

❑ Other _____

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

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
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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:

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 receive any Veteran's Affairs (VA) benefits? ❑ Yes ❑ No

   If "yes," which VA Facility? _____

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

   If yes, please provide your Medicaid number: _____

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

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, Worker's Compensation, 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 1-877-795-6117 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

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 **(*or* Part A or B for PDP)**. I can be in only one Medicare Advantage or PDP plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health 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.

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.**

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

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.

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: _____