



# Medicare Advantage Health Plans INDIVIDUAL Enrollment Application

2011  
Rochester  
Region

## BY COMPLETING THIS ENROLLMENT APPLICATION, I AGREE TO THE FOLLOWING:

MVP Health Plan, Inc. 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 (Example: October 15 - December 7 of every year), or under certain special circumstances.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP 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 MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP 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 HMO plan coverage begins, I must get all of my health care from MVP, except for emergency or urgently needed services or out-of-area dialysis services; **OR**

I understand that beginning on the date my PPO 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 PPO plan provides refunds for covered benefits, even if I get services out of network. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MVP 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 MVP, he/she may be paid based on my enrollment in MVP.

## STOP

### PLEASE READ THIS IMPORTANT INFORMATION

**If you currently have health coverage from an employer or union, joining an MVP Medicare Advantage plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MVP.** Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

### Section 1: Plan enrollment selection for individual members

▼ **PLEASE CHECK** which plan you want to enroll in:

- GoldValue HMO** **with** prescription coverage, \$48.00 monthly premium
- Preferred Gold HMO** **without** prescription coverage, \$37.60 monthly premium
- Preferred Gold HMO** **with** prescription coverage, \$103.70 monthly premium
- GoldAnywhere PPO** **with** prescription coverage, \$241.20 monthly premium

▼ **SELECT PAYMENT** method:

- Please bill me.
- Automatic deduction from my monthly SSA benefit check. (The first deduction may take several months to begin. Continue to pay your bill until the deduction starts.)
- Direct debit or credit card (submit form)

If you don't select a payment option, MVP will bill you monthly.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. 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).

**Note:** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay part of your plan premium. We will bill you for the amount that Medicare does not cover.

### Section 2: Please provide the following information:

\_\_\_\_\_  
**LAST** Name                      **FIRST** Name                      Mid. Init.

\_\_\_\_\_  
Permanent Residence Street Address (P.O. Box is not allowed)

\_\_\_\_\_  
City                      State                      ZIP Code                      County

\_\_\_\_\_  
Home Phone #                      Date of Birth

Gender:  Male  Female

\_\_\_\_\_  
Mailing Address (if different from permanent address — include number, street, and apt. #)

\_\_\_\_\_  
City                      State                      ZIP Code                      County

### Section 3: Please provide your Medicare insurance information

**USE** your Medicare card to complete this section. Please fill in these blanks so they match your red, white and blue Medicare card.

#### Medicare Health Insurance

\_\_\_\_\_  
Name

\_\_\_\_\_  
Medicare Claim #

Is Entitled To:

Hospital (Part A)    \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Medical (Part B)    \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

### Section 4: Primary Care Physician (PCP) - not required for GoldAnywhere

\_\_\_\_\_  
Primary Care Physician  
(full name required)

Existing patient?  Yes  No

### Section 5: Please read and answer these important questions

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

If you answered "yes" to this question and you don't need regular dialysis, 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.** Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or EPIC.

Will you have other prescription drug coverage in addition to MVP?     Yes  No

*Continued next page*

If yes, name of other coverage: \_\_\_\_\_  
ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_

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 Medicare later determines that this information is incorrect, you may be disenrolled.

**Your answer to the following questions will not keep you from enrolling in this plan.**

3. Are you a resident in a long-term care facility, such as a nursing home?  Yes  No  
If yes, name of institution: \_\_\_\_\_

Admission date: \_\_\_\_\_  
Address (# & street): \_\_\_\_\_

Phone: \_\_\_\_\_

4. Are you enrolled in your State Medicaid program?  Yes  No  
If yes, please provide your Medicaid number: \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

- I am new to Medicare (turning 65 or due to disability).
- 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: \_\_\_\_\_.
- 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: \_\_\_\_\_.
- I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). Move date: \_\_\_\_\_.
- I recently left a PACE program on: \_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) on \_\_\_\_\_.
- I am leaving employer or union coverage on: \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state (EPIC).
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: \_\_\_\_\_.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- None of these statements applies to me\*

\*Please call us to see if you are eligible to enroll:  
**1-888-280-6205 or TTY: 1-800-662-1220.**

**Section 6: Signature and Authorization**

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

**PLEASE SIGN BELOW**

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 \_\_\_\_\_

## Questions?

**Call Medicare Sales:  
1-888-280-6205**

**TTY: 1-800-662-1220**

Monday - Friday, 8 am - 5 pm Eastern Time  
From November 15 - March 1,  
representatives are available every day from 8 am - 8 pm.

Please contact MVP if you need information in another language or format (Braille).

**MVP Health Care  
Medicare Sales  
220 Alexander St.  
Rochester, NY 14607**

### For Plan Use Only

**Enter in:**

**Amisys**

**Facets**

If current member, please include member ID number:

A

OR

8

Previous ID # \_\_\_\_\_ Group Name \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date Requested \_\_\_\_\_ Input Date \_\_\_\_\_ Initials \_\_\_\_\_

ICEP/IEP     AEP     SEP (type): \_\_\_\_\_ Not eligible: \_\_\_\_\_

Date coverage should begin: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_