



Medicare Advantage Health Plans INDIVIDUAL Enrollment Application

2012
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 Advantage 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 beginning on the date my HMO-POS or 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, MVP provides reimbursements 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 THESE 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.

Step 1: Plan enrollment selection for individual members

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

- GoldValue HMO-POS** **with** prescription coverage, \$0.00 monthly premium
- Preferred Gold HMO-POS** **without** prescription coverage, \$0.00 monthly premium
- Preferred Gold HMO-POS** **with** prescription coverage, \$102.50 monthly premium
- GoldAnywhere PPO** **with** prescription coverage, \$254.90 monthly premium

▼ **SELECT PAYMENT** method for your monthly premium and/or any late enrollment penalty you may owe:

- Please bill me.
- Automatically deduct from my monthly Social Security or Railroad Retirement Board 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. See page 4 for information on how you may qualify for extra help with your premium and drug costs.

Step 2: Please provide the following information:

LAST Name FIRST Name Mid. Init.

Permanent Residence (**Home**) 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 home address — include number, street, and apt. #)

City State ZIP Code County

Email Address (optional)

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

Medicare Health Insurance

Name _____

Medicare Claim # _____

Is Entitled To:

Hospital (Part A) ___ / ___ / ___

Medical (Part B) ___ / ___ / ___

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

Primary Care Physician (full name required)

Existing patient? Yes No

Step 5: Please read and answer these important questions

1. 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.
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage or VA benefits. Will you have other prescription drug coverage in addition to MVP? Yes No
If yes, name of other coverage: _____
ID #: _____
Group #: _____

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

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

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

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.

- 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 recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. 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).
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____.
- 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.**

Step 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 from 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 _____

RETURN THIS COPY TO MVP.

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 coinsurance. 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**.

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.

If you are assessed a Part D-Income Related Monthly Adjustment Amount by Medicare, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT** pay MVP the Part D-IRMAA.

Ready to join MVP now? It's easy!

Here are three ways you can enroll:

- 1.** Call us to enroll over the phone in minutes! MVP Medicare Products Advisors are ready to serve you Monday - Friday, 8 am to 5 pm Eastern Time at **1-888-280-6205**. TTY users may call 1-800-662-1220. Or call our Medicare Customer Care Center at **1-800-665-7924**. From Oct. 15 - Feb. 14, call seven days a week from 8 am to 8 pm.
- 2.** Enroll online by going to **www.mvphealthcare.com**. Call us if you need help!
- 3.** Complete, sign, and date this enrollment application — one for each eligible person.

Please contact MVP if you need this information explained to you in another language, or provided in a different format (Braille).

**MVP Health Care
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