

# MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT ELECTION FORM



Please contact ONECare by Care1st Health Plan Arizona, Inc. (HMO) if you need information in another language or format (Braille).

## TO ENROLL IN ONECARE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

### 1. Personal Information

LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms
------------	-------------	-----------------	--

Birth Date: (__/__/____) (MMDDYYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	E-mail Address:	Home Phone Number: ( )
			Cell Phone Number: ( )

Permanent Residence Street Address (PO Box is not allowed):

City:	State:	ZIP Code:
-------	--------	-----------

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

Street Address:	City:	State:	ZIP Code:
-----------------	-------	--------	-----------

Emergency contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

### 2. Please provide your Medicare Insurance Information.

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
- OR-
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

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

**This enrollment application will not be complete until you have provided us with this information.**

<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number _____			Sex _____	
- - - - -				
Is Entitled To			Effective Date	
<b>HOSPITAL(Part A)</b>			_____	
<b>MEDICAL (Part B)</b>			_____	

### 3. Paying Your Plan Premium

**If you have a monthly plan premium, you can pay it by mail each month. If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay your late enrollment penalty by mail each month. You can also choose to pay your monthly plan premium and/or late enrollment penalty by automatic deduction from your Social Security benefit check each month.**

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

WHITE – Enrollment Copy      YELLOW – Office Copy      PINK – Member's Copy

about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

**If you don't select a payment option, you will get a bill each month.**

Please select a premium payment option:

- Get a bill
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

**4. 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 anymore, 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 State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to ONECare? 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:
-------------------------	------------------------	----------------------------

3. 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) \_\_\_\_\_

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

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

Physician's Name	ID Number	Medical Group / IPA Name
------------------	-----------	--------------------------

--	--	--

Are you an existing patient of this doctor?  Yes  No

**6. Other Information**

Please check one of the boxes below if you would prefer us to send you information in a language other than English:  Spanish  Other Language

Contact us if you need a format like Braille, audiotope or large print.

Please contact ONECare by Care1st Health Plan Arizona, Inc. (HMO) Member Services at **(602) 778-8345** or **1-877-778-1855** (TTY users should call **1-800-367-8939**) if you need information in another format or language than what is listed above. Our office hours are from 8:00 AM to 8:00 PM, 7 days a week.



### Please Read This Important Information

**If you currently have health coverage from an employer or union, joining ONECare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join ONECare.** 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 any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

#### 7. Signature: Please Read and Sign Below

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

ONECare by Care1st Health Plan Arizona, Inc. (HMO) is a Medicare Advantage Special Needs 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: November 14- December 31 of every year) or under certain special circumstances.

ONECare by Care1st Health Plan Arizona, Inc. (HMO) serves a specific service area. If I move out of the area ONECare 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 ONECare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from ONECare 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 US border.

I understand that beginning on the date ONECare coverage begins, I must get all of my health care from ONECare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by ONECare and other services contained in my ONECare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ONECARE 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 ONECare, he/she may be paid based on my enrollment in ONECare.

Release of Information: By joining this Medicare health plan, I acknowledge that ONECare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that ONECare will release my information including my prescription drug event data to Medicare, who may release it for search 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 ONECare or by Medicare.

<b>Enrollee Signature:</b> _____	<b>Today's Date:</b> _____
----------------------------------	----------------------------

If you are the authorized representative, you must provide the following information:

**Authorized Representative Name (print):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_\_ **Relationship to Enrollee** \_\_\_\_\_

**Authorized Representative Signature:** \_\_\_\_\_

**8. Plan Representative Section**

**Plan Representative Signature:** \_\_\_\_\_

**Plan Representative Name (print):** \_\_\_\_\_

**Plan Representative Number:** \_\_\_\_\_

**Plan Representative Phone Number:** \_\_\_\_\_

OFFICE USE ONLY	EFF. DATE OF COVERAGE	ENROLLEE ID #	APPLICATION #	BATCH #
	ENROLLED IN: _____ ADVANTAGE (MA-PD) _____ NOT ELIGIBLE			



## **MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT ELECTION FORM**

- Step 1:** Please fill out the application completely.  
Use a ballpoint pen and press hard to make three copies.
- Step 2:** Sign and date the last page of the application.
- Step 3:** Keep the bottom pink copy for your file.

*If you have any questions regarding this application, please call:*

**1-877-778-1855 Option # 7 \***  
**TTY/TDD 1-800-367-8939**  
**Hours: 8:00 a.m. to 6:00 p.m.**  
**Monday through Friday**

**ONECare by Care1st Health Plan Arizona, Inc. (HMO)**  
**2355 E. Camelback Road**  
**Suite 300**  
**Phoenix, AZ 85016**  
**[www.care1st.com/az](http://www.care1st.com/az)**

**Member Services: 1-877-778-1855**  
**TTY/TDD 1-800-367-8939**  
**Hours: 8:00 a.m. to 8:00 p.m.**  
**7 days a week**

\* Calling this number will direct you to a licensed insurance agent/broker. Calling the ONECare by Care1st Health Plan Arizona, Inc. (HMO) number above will allow you to get plan information and enroll in the plan if you choose to.

For enrollments after October 1, 2010, effective dates November or December 1, 2010: Benefits formulary, pharmacy, network, premium and/or co-payments/co-insurance may change on January 1, 2011. Please contact ONECare by Care1st Health Plan Arizona, Inc. (HMO) for details.