Health Alliance MEDICARE℠

Enrollment Request Form – Illinois and Western Indiana HMO and POS Plans

January 1, 2018 – December 31, 2018

2018

Toll-free 1-888-382-9771
TTY 711
HealthAllianceMedicare.org

med-IL2018enrlmtfrm-0417 • H1463_18_54868_FINAL
Approved 7/28/2017

One Step at a Time

Follow these simple instructions to enroll in a Health Alliance Medicare plan.

1. Please read the entire Enrollment Request Form carefully to be sure you understand the information and what is being asked.

2. You can save time by having the following information handy:
   - Your red, white and blue Medicare card. You will need to fill in the information on the Enrollment Request Form exactly as it appears on your Medicare card.
   - Your Medicaid program number, if you have one.
   - Card(s) for any other health insurance you may have besides Medicare and/or Medicaid.

3. Sign and date the Enrollment Request Form.
   This form is not complete without your signature and date. If you don't sign and date this form, it will delay your enrollment. If an authorized legal representative completed the form on your behalf, he or she will need to sign the form and complete the information in the box immediately below the signature. If an authorized legal representative completed the Enrollment Request Form, legal documentation must be provided upon request.

4. Keep the pink member copy for your records.
   Please keep the member copy of the completed Enrollment Request Form in a safe place for future reference.

5. Please fold the completed original white copy and place in the enclosed postage-paid, self-addressed envelope.

If you have any questions, please call Health Alliance Medicare Services at 1-888-382-9771 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from February 15 to September 30.

Health Alliance Medicare is a Medicare Advantage Organization with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.

You must continue to pay your Medicare Part B Premium.

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HMO & POS, Illinois and Western Indiana

Health Alliance MEDICARE℠

1-888-382-9771
301 S. Vine St., Urbana, IL 61801

MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Agent/Office Staff Use Only:
Name of staff member/agent/broker (if assisted in enrollment): _____
Date Received: _____ Effective Date of Coverage: _____ NIPR#: _____
ICEP/IEP: _____ AEP: _____ SEP(type): _____

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

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

Please check which plan you want to enroll in:

❑ POS Basic (HMO-POS)	$23 per month	❑ HMO Basic (HMO)	$0 per month
❑ POS Basic Rx (HMO-POS)	$52 per month	❑ HMO Basic Rx (HMO)	$33 per month
❑ POS 30 (HMO-POS)	$59 per month	❑ HMO 40 (HMO)	$39 per month
❑ POS 30 Rx (HMO-POS)	$96 per month	❑ HMO 40 Rx (HMO)	$72 per month
❑ POS 10 (HMO-POS)	$124 per month	❑ HMO 20 (HMO)	$85 per month
❑ POS 10 Rx (HMO-POS)	$156 per month	❑ HMO 20 Rx (HMO)	$116 per month

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 *(P.O. Box is not allowed)*:

Street Address: _____

City: _____ State: _____ ZIP Code: _____ County: _____

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

Street Address: _____

City: _____ State: _____ ZIP Code: _____ County: _____

Email Address:

Please choose the name of a Primary Care Physician (PCP):

Please list the name of your previous health insurance provider:

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.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or by credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D Income-Related Monthly Adjustment Amount (IRMAA), 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 Health Alliance Medicare the Part D IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent 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.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of the 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 monthly.

❑ Electronic Funds Transfer (EFT) from your bank account around the 10th day of each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account Type: ❑ Checking ❑ Savings

❑ Automatic recurring credit card transaction around the 1st of every month. Please provide the following:

Type of Card: _____

Name of account holder as it appears on card: _____

Account number: _____

Expiration date: __ __ / __ __ __ __ (MM/YYYY) Three-digit security code: _____

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ❑ Social Security ❑ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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

   If "yes," which VA Facility? _____

3. 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: _____

4. 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): _____

   _____

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

   If yes, please provide your Medicaid number: _____

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

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

____ Spanish ____ Large Print

Please contact Health Alliance Medicare at 1-888-382-9771 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711. Voicemail is used on holidays and weekends from February 15 to September 30.

STOP — Please Read This Important Information

If you currently have health coverage from an employer or union, joining Health Alliance Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Alliance Medicare. 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.

Please Read and Sign on Next Page

<u>By completing this enrollment application, I agree to the following</u>:
Health Alliance Medicare 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 through December 7 of every year), 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 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.

For POS 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.**

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.**

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 from Medicare.

Signature: X	**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).