**PRESBYTERIAN** Presbyterian Senior Care

# Presbyterian Senior Care Individual Enrollment *Request* Form

## To Enroll in Presbyterian Senior Care, Please Provide the Following Information:

**Please check which plan you want to enroll in:**

| | Plan | Premium |
|---|---|---|
| _____ | Presbyterian Senior Care Plan 1 (Medical Benefits Only) | $0 per month |
| _____ | Presbyterian Senior Care Plan 2 with Rx | $0 per month |
| _____ | Presbyterian Senior Care Plan 3 with Rx | $57 per month |

LAST name: FIRST Name: Middle Initial ❑ Mr. ❑ Mrs. ❑ Ms.

| Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) | Sex: ❑ M ❑ F | Social Security Number: *(providing this information is optional)* | Home Phone Number: ( ) |
|---|---|---|---|

Permanent Residence Street Address:

| 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:** ________________

**E-mail Address:**

## 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.

Name: ______________________

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To: Effective Date

**HOSPITAL (Part A)** ____________

**MEDICAL (Part B)** ____________

SAMPLE ONLY

## Paying Your Plan Premium:

*Presbyterian Senior Care Plan 3 with Rx:* **You can pay your monthly plan premium by mail. We will send you a bill each month. You may also pay by Electronic Funds Transfer (EFT), charge to your credit card each month (Presbyterian Senior Care accepts MasterCard and VISA) or you may pay your premium annually. You can also choose to pay your premium by automatic deduction from your Social Security check each month.**

*Presbyterian Senior Care Plan 1 and Presbyterian Senior Care Plan 2 with Rx:* **If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail. You may also pay by Electronic Funds Transfer (EFT) or charge to your credit card (Presbyterian Senior Care accepts MasterCard and VISA). You can also choose to pay your premium by automatic deduction from your Social Security check each month.**

Copy 1: Enrollment Copy 2: Member

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 this premium, we will bill you for the amount that Medicare does not cover.

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

**Please select a payment option:**

❑ Receive a bill monthly.

❑ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
Account Holder Name: ______________________________
Bank Routing Number: ______________ Bank Account Number: ______________
Account Type: ❑ Checking ❑ Savings

❑ Credit Card. Please provide the following information:
Type of Card: ______________________________
Name of Account Holder as it appears on Card: ______________________________
Account Number: ______________ Expiration Date: _____ / ________ (MM/YYYY)

❑ Automatic Deduction from your *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.)

## 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 do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not 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 Presbyterian Senior Care? ❑ 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 & 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

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

**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 _____ Audio tape

If you need information in another format or language than what is listed above, please contact Presbyterian Senior Care at (505) 923-6060 or 1-800-797-5343, Monday through Sunday from 8 a.m. to 8 p.m. TTY users should call 1-888-625-8818.

## Please Read This Important Information

**If you currently have health coverage from an employer or union, joining Presbyterian Senior Care could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Presbyterian Senior Care may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## Please Read and Sign Below:

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

Presbyterian Senior Care is a Medicare Advantage plan and *has a contract with the Federal government.* I will need to keep my Parts A and B. I can only be in 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 do not 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 15 – December 31 of every year), or under certain special circumstances.*

Presbyterian Senior Care serves a specific service area. If I move out of the area that Presbyterian Senior Care 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 Presbyterian Senior Care, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Member Handbook/Evidence of Coverage* document from Presbyterian Senior Care when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Presbyterian Senior Care coverage begins, I must get all of my health care from Presbyterian Senior Care, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Presbyterian Senior Care and other services contained in my Presbyterian Senior Care *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PRESBYTERIAN SENIOR CARE WILL PAY FOR THE SERVICES.**

*I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Presbyterian Senior Care, he/she may be compensated based on my enrollment in Presbyterian Senior Care.*

*Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.*

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Presbyterian Senior Care 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 behalf of the individual under the laws of the State where the individual resides) 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 Presbyterian Senior Care or by Medicare.

| **Your 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:** ______________________________

**Office Use Only:**

Name of staff member (if assisted in enrollment): ______________________

Plan ID #: ______________________________

Effective Date of Coverage: ______________________________

ICEP/IEP: __________ OEP: __________ AEP: __________ SEP (type): __________

Copy 1: Enrollment Copy 2: Member