

Enrollment Request Form

January 1, 2012 – December 31, 2012

2012

Toll-free 1-800-965-4022

TTY/TDD 711 or 1-800-526-0844 (Illinois Relay)

HealthAllianceMedicare.org

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 and yellow plan copies and place in the enclosed postage-paid, self-addressed envelope.

If you have any questions, please call Health Alliance Medicare Services at 1-800-965-4022, TTY/TDD 711 or 1-800-526-0844 (Illinois Relay), daily, 8 a.m. to 8 p.m.

HealthAllianceMEDICARE

1-800-965-4022

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HealthAllianceMedicare.org

HealthAlliance**MEDICARE**

1-800-965-4022
301 S. Vine St.
Urbana, IL 61801

MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____
Plan ID # _____ Effective Date of Coverage: _____ NIPR#: _____
ICEP/IEP: _____ AEP: _____ SEP(type): _____ Not Eligible: _____

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:

- | | | | |
|--|-----------------|--|-----------------|
| <input type="checkbox"/> Medicare PPO 10 | \$110 per month | <input type="checkbox"/> Medicare HMO 20 | \$100 per month |
| <input type="checkbox"/> Medicare PPO 10Rx | \$154 per month | <input type="checkbox"/> Medicare HMO 20Rx | \$144 per month |
| <input type="checkbox"/> Medicare PPO 30 | \$45 per month | | |
| <input type="checkbox"/> Medicare PPO 30Rx | \$89 per month | | |

LAST name: _____ FIRST name: _____ Middle Initial _____
 Mr. Mrs. Ms.

Birth Date: (____/____/____) MM DD YY YY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: () -	Alternate Phone Number: () -
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Permanent Residence (*P.O. Box is not allowed*):

Street Address: _____
City: _____ State: _____ ZIP Code: _____

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

Street Address: _____
City: _____ State: _____ ZIP Code: _____

Email Address: _____

For HMO plans only:

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

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 Social Security or the Railroad Retirement Board.

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

Medicare Health Insurance Sample Only

Name: _____
Medicare Claim Number: _____ - _____ - _____
Sex: _____
Is Entitled To: _____ Effective Date: _____
Hospital (Part A) _____
Medical (Part B) _____

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 Saving

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 monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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. 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 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: _____

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

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 1-800-965-4022 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/TDD users should call 711 or 1-800-526-0844 (Illinois Relay).

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

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

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 PPO 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: _____	Today's Date: _____
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If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number (_____) _____ - _____

Relationship to Enrollee: _____