

HealthAlliance**MEDICARE**

Health Alliance Medicare Stand-Alone Prescription Drug Plan Individual Enrollment Form

Toll-free 1-800-965-4022
TTY/TDD 711 or 1-800-526-0844 (Illinois Relay)
HealthAllianceMedicare.org

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One Step at a Time

Follow these simple instructions to enroll in a Health Alliance Medicare Stand-Alone Prescription Drug Plan.

1. Please read the entire Enrollment 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 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 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 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 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 at 1-800-965-4022, TTY/TDD 711 or 1-800-526-0844 (Illinois Relay) daily, 8 a.m. to 8 p.m.

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

HEALTH ALLIANCE MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

Office Use Only:

Name of plan representative/agent/broker: _____
Plan ID # _____ Effective Date of Coverage: _____
IEP: _____ AEP: _____ SEP(type): _____ NIPR #: _____

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

To Enroll in a Health Alliance Medicare Stand-Alone Part D Plan, Please Provide the Following Information:

Please check the plan you want to enroll in:

Basic (PDP): \$46.60 per month

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

Birth Date: _____ Sex: _____ Home 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: _____

Emergency Contact: _____
Phone Number: () - _____ Relationship to You: _____

Email 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 Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare prescription drug 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 by mail (including any late enrollment penalty you may owe), 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 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D IRMAA extra amount to Health Alliance Medicare.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a 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/TDD 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 receive a bill each month.

Please select a premium payment option:

Receive a bill each month.

- 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. 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 answer the following questions:

1. 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 a Health Alliance Medicare Stand-Alone Prescription Drug Plan?

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: _____

2. 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): _____

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:

Large print Spanish

Please contact Health Alliance Medicare at 1-800-965-4022 if you need information in another format or language than what is listed above. TTY/TDD users should call 711 or 1-800-526-0844 (Illinois Relay). Our office hours are 8 a.m. to 8 p.m., daily.

STOP — Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Health Alliance Medicare Stand-Alone Prescription Drug Plan, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Health Alliance Medicare Stand-Alone Prescription Drug Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Alliance Medicare Stand-Alone Prescription Drug Plan. 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 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 Stand-Alone Prescription Drug Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Health Alliance Medicare of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in Health Alliance Medicare Stand-Alone Prescription Drug Plan will end that enrollment.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Health Alliance Medicare Stand-Alone Prescription Drug Plan serves a specific service area. If I move out of the area that Health Alliance Medicare Stand-Alone Prescription Drug Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Health Alliance Medicare Stand-Alone Prescription Drug Plan network pharmacies. Once I am a member of Health Alliance Medicare Stand-Alone Prescription Drug Plan, 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.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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 Stand-Alone Prescription Drug Plan.

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

Release of Information:

By joining this Medicare prescription drug 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 State law 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 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: _____