

# 2018 MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT FORM



You may not select your effective date of coverage. Alignment Health Plan will formally notify you when you may begin using plan services.

Effective Date: \_\_\_\_\_

Please check which Alignment Health Plan option you want to enroll in.

- 001-My Choice Plan (HMO)** ..... \$0/month  
Los Angeles, Orange, Riverside and San Bernardino Counties
- 009- CalPlus Plan (HMO)** ....\$0/month Part C \$35.50/month Part D\*  
Los Angeles, Orange, Riverside, San Bernardino, San Joaquin, Santa Clara and Stanislaus Counties
- 006-My Choice Plan (HMO POS)**..... \$19/month  
San Joaquin and Stanislaus Counties
- 013-smartHMO (HMO)**..... \$0/month  
Los Angeles and Orange Counties
- 007-My Choice Plan (HMO)** ..... \$12/month  
Santa Clara County
- 011-AllCare Preferred Plan (HMO)** .....  \$0/month  
Stanislaus County .....  \$14/Optional Supplemental Benefits
- 008-Platinum Plan (HMO)**..... \$0/month  
Los Angeles and Orange Counties

*\*For CalPlus (HMO) depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for your part D premium.*

### Tell Us About Yourself (Please Print)

Name As It Appears On Your Medicare Card (Last)		(First)	(M.I.)
Permanent Residence Address		City	Zip Code
Mailing Address (If different from above)		City	Zip Code
Home Telephone Number	Sex	Birthday (MM/DD/YY)	*Your E-mail Address (Optional)

**By giving my email address, I agree to receive emails about my benefits, health programs and other plan services. I understand I may change my email preferences at any time by calling 1-888-979-2247 (TTY 711). 8am-8pm, 7 days a week (except Thanksgiving and Christmas) from October 1 - February 14 and Monday through Friday (except holidays) from February 15 through September 30.**

What Is Your Primary Language? (Check One)

- English  Spanish  Other \_\_\_\_\_

How would you prefer to receive your member information:  Print  E-mail  CD  Website

Please contact Alignment Health Plan at 1-888-979-2247 (TTY 711) if you need information in another format or language than what is listed above. Our office hours are 8am - 8pm, 7 days a week (except Thanksgiving and Christmas) from October 1 - February 14 and Monday - Friday (except holidays) from February 15 - September 30.

<p><b>Please Provide Your Medicare Insurance Information</b></p> <p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>• Please fill in these blanks so they match your red, white and blue Medicare card</li> <li>- OR -</li> <li>• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	<p>Name (as it appears on your Medicare card): _____</p> <p>Medicare Number: _____</p> <p>Is Entitled To _____ Effective Date _____</p> <p><b>HOSPITAL (PART A)</b> _____</p> <p><b>MEDICAL (PART B)</b> _____</p> <p>You must have Medicare Part A and Part B to join a Medicare Advantage Plan.</p>
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Medical Group	Personal Primary Care Physician Name	IPA/Primary Care Physician ID Number
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Check either **Yes** or **No** to each question:

1.	Do you have End Stage Renal Disease (ESRD)?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If you have had a successful kidney transplant and/or you don't need regular dialysis any more, <i>please attach a note or records</i> 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.	Are you a resident in a long-term care facility, such as a nursing home?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, name of institution _____ Telephone number of institution _____		
	Address of institution (number and street) _____		
3.	Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceuticals assistance programs.		
	Will you have other prescription drug coverage in addition to Alignment Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If "Yes" please list your coverage and your identification (ID) number(s) for this coverage:		
	Name of other coverage _____		
	Group # for this coverage _____ ID # for this coverage _____		
4.	Are you eligible for State Medicaid (Medi-Cal)?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Are you enrolled in your State Medicaid Program (Medi-Cal)?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, please provide your Medi-Cal Number _____		
6.	Do you or your spouse work? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	I understand that by selecting my Personal Primary Care Physician I am also selecting the physician group, hospitals and specialists associated with my Personal Primary Care Physician. ....		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you been given a Alignment Health Plan Summary of Benefits and instructions on how to obtain a Provider Directory?.....		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Paying your Plan Premium:** You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe). 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, 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 the RRB. DO NOT pay Alignment Health Plan 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% of 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 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](http://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 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 plan premium and/or late enrollment payment option:

- Get a bill
- 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 This Important Information

**If you currently have health coverage from an employer or union, joining Alignment Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Alignment Health 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 any 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:**

Alignment Health Plan 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 – December 7 of every year), or under certain special circumstances.

Alignment Health Plan serves a specific service area. If I move out of the area that Alignment Health Plan 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 Alignment Health 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 Alignment Health Plan 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 beginning on the date Alignment Health Plan coverage begins, I must get all of my health care from Alignment Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Alignment Health Plan and other services contained in my Alignment Health Plan Evidence of Coverage document (also known as a member

contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR ALIGNMENT HEALTH PLAN 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 Alignment Health Plan, he/she may be paid based on my enrollment in Alignment Health Plan.

**Release of Information:** By joining this Medicare health plan, I acknowledge that Alignment 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 Alignment Health Plan 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 \_\_\_\_\_

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

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship to Enrollee \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Emergency Contact Telephone Number \_\_\_\_\_

Emergency Contact E-Mail \_\_\_\_\_ Relationship to Enrollee \_\_\_\_\_

Name of Sales Representative (if assisted with Enrollment):

Enrolling Sales Representative's Signature \_\_\_\_\_ Sales #ID \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Phone Number \_\_\_\_\_

Office Use Only:

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP(Type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_