



Individual Enrollment Request Form

Please contact FamilyCare HealthPlans, Inc., if you need information in another language for format (Braille).

To enroll in PremierCare, please provide the following information:

Please check which plan you want to enroll in? Choice \$49 month Choice Rx \$74 month Plus \$0 month Value Rx \$125 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 () -

Permanent Residence Street Address (PO Box is not allowed):

City: State: ZIP code:

Mailing address (Only if different from your Permanent Residence Address):

Street address: City: State: ZIP code:

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.

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 you may owe) by mail or Electronic Funds Transfer (EFT) 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, 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 FamilyCare Health Plans, Inc., 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% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it.—CONTINUES ON NEXT PAGE

CONTINUED FROM PREVIOUS PAGE—For more information about this extra help, contact your 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 this 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 coupon book.

Please select a premium payment option:

- Get a coupon book
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOID-ED check *and* the enclosed *Quick Pay* form.
- 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 the 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 coupon book 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 your PremierCare plan? Yes No

If "yes," please list your other coverage and your ID number(s) for this coverage:

Name of other coverage _____ ID# for this coverage _____ Group # for this coverage _____

3. Are you a resident of a long-term facility such as a nursing home? Yes No

If "yes," please provide the following information:

Name of institution _____ Address for this 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 at right if you would prefer us to send you information in a language other than English or in another format.

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Braille |
| <input type="checkbox"/> Russian | <input type="checkbox"/> Audiotape |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Large print |

Please contact FamilyCare Health Plans, Inc., toll-free at 1-866-798-CARE (2273) if you need information in another format or language than what is listed above. Our office hours are 8 am-8 pm, Monday-Friday. TTY users should call 1-800-735-2900 toll-free.



READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining a PremierCare Medicare Advantage plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a PremierCare Medicare Advantage 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:

FamilyCare Health Plans, Inc., 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.

PremierCare Choice only: 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.

PremierCare Medicare Advantage Plans serve a specific service area. If I move out of the area that PremierCare 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 a PremierCare 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 PremierCare 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 US border.

I understand that beginning on the date PremierCare plan coverage begins, I must get all of my health care from PremierCare, except for emergency or urgently needed services or out-of-area dialysis services. — CONTINUES ON NEXT PAGE

CONTINUED FROM PREVIOUS PAGE— Services authorized by FamilyCare and other services contained in my PremierCare plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PREMIERCARE 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 FamilyCare Health Plans, Inc., he/she may be paid based on my enrollment in a PremierCare Medicare Advantage plan.

Release of Information: By joining this Medicare health plan, I acknowledge that FamilyCare Health Plans, Inc., will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that FamilyCare will release my information, including my prescription drug event data, to Medicare, which may release it for research and other purposes that 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:		

Office Use Only			
Name of staff member/agent/broker (if assisted in enrollment): _____			
Plan ID #: _____	Effective date of coverage: _____		
ICEP/IEP: _____	AEP: _____	SEP (type): _____	Not Eligible: _____



FamilyCare Health Plans, Inc.
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www.familycarehealthplans.org

1-866-225-CARE (2273)
 Fax: 503-345-5751
 TTY: 1-800-735-2900
 7 days a week, 8 am-8 pm

HOW TO USE THIS FORM

1. Remove the form from this booklet and use the vertical perforations to separate the form into four separate pages.
 - Don't tear the perforations at the top of the pages until AFTER you've finished filling out the form.
2. Use a ballpoint pen and press firmly.
 - Each page has a front sheet and a back sheet. When you press on the front sheet, it copies your hand writing on the second sheet.
 - Don't "stack" page 1 on top of page 2, and so on, when you fill out the form. If you stack pages, it will smudge the copies.

ENROLLMENT CHECKLIST

- Choose a PremierCare plan to enroll in (Page 1)
 - Complete Medicare information (Page 1)
 - Select a premium payment method (Page 2)
 - Read and answer the important questions on Page 2
 - Sign and date the *Enrollment Request Form* (Page 4)
 - If an authorized representative signs for you, complete the authorized representative information (Page 4)
 - Separate the front and back sheets of the *Enrollment Request Form*
 - Use the postage-paid business reply envelope; Include:
 - All four front (white) sheets of the *Enrollment Request Form*
 - Attestation of Eligibility* form (Signed and dated)
- If you choose to pay your premium by electronic funds transfer, be sure to include:
- QuickPay Form* (Signed & dated)
 - Voided check