SHORT ENROLLMENT REQUEST FORM

Please check which plan you want to enroll in:	❑ Choice $49 month	❑ Choice Rx $74 month	❑ Plus $0 month	❑ Value Rx $125 month

Your name:

Medicare number:

Home phone number:

Permanent Street Address (PO Box is not allowed):

City: State: ZIP code:

Mailing address (only if different from your Permanent Street Address):

Street address: City: State: ZIP code:

Please fill out the following:

I am currently a member of the ____________________ plan in FamilyCare Health Plans with a monthly premium of $________________ .

I would like to change to the ____________________ plan in in FamilyCare Health Plans. I understand that this plan has different health benefits and a monthly premium of $________________ .

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.

❑ Spanish ❑ Braille
❑ Russian ❑ Audiotape
❑ Vietnamese ❑ Large print

Please contact FamilyCare Health Plans, Inc., toll-free at 1-866-225-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.

Your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you have or 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 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 Railroad Retirement Board. Do NOT pay FamilyCare Health Plans the Part D IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 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 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 for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Continues on page 2

Continued from page 1

If you don't select a payment option, you will get a coupon book.

Please select a premium payment option:

- ❑ Get a coupon book
- ❑ Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security 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 when 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.)
- ❑ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check and the enclosed Quick Pay form.

Please read and sign below

FamilyCare Health Plans, Inc., is a plan and has a contract with the Federal government.

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 the Medicare health plan 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 people with Medicare aren't 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. 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 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.
825 NE Multnomah, Suite 300
Portland, OR 97232
www.familycarehealthplans.org

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