

Individual Enrollment Request Form

Member Name _____ Agent Name and Number _____

Please contact Network Health Insurance Corporation if you need information in another language or format (Braille).

To Enroll in Network PlatinumPlus, Network PlatinumPremier, Network PlatinumSelect or NetworkCares Please Provide the Following Information:

Please check which plan you want to enroll in:

- Network PlatinumSelect with Pharmacy \$0 per month
- Network PlatinumPlus \$28 per month Network PlatinumPlus Pharmacy \$62 per month
- Network PlatinumPremier \$66 per month Network PlatinumPremier Pharmacy \$115 per month
- NetworkCares with Pharmacy \$0 per month

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (__ / __ / __ __ __ __) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate Phone Number: ()
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Permanent Residence Street Address: *(P.O. Box is not allowed)*

City:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____

State: _____ Zip Code: _____

Emergency contact: _____

Phone Number _____ **Relationship to you** _____


E-mail 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 Advantage plan.

MEDICARE		HEALTH INSURANCE
SAMPLE ONLY		
Name: _____		
Medicare Claim Number	Sex _____	
_____ - _____ - _____		
Is Entitled To	Effective Date	
HOSPITAL (Part A)	_____	
MEDICAL (Part B)	_____	

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Paying Your Plan Premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

***NOTE: When enrolling in Network PlatinumSelect, if we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.**

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 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 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 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 **VOIDED** check or provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: Checking Savings
- Automatic deduction from your monthly *Social Security* benefit check. (The *Social Security* deduction may take two or more months to begin. In most cases, the first deduction from your *Social Security* benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

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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: Network Platinum^{Plus} with/without Pharmacy or Network Platinum^{Premier} with/without Pharmacy, Network Platinum^{Select} or Network^{Cares}? 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 & 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

6. (Optional) Who is your Primary Care Provider (PCP) or family doctor?

Name: _____ Phone Number: _____

7. Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15th and December 31st of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1st and March 31st of each year, as long as you don’t add or drop your prescription drug coverage. (*i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don’t have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage*).

Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (*insert date*) _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help in paying for my Medicare prescription drugs. I stopped receiving extra help on (*insert date*) _____.

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I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or other long term care facility). I moved/will move into/out of the facility on *(insert date)* _____.

I recently left a "PACE" program on *(insert date)* _____.

I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on *(insert date)* _____.

I am leaving employer or union coverage on *(insert date)* _____.

I belong to a pharmacy assistance program provided by my state.

I recently returned to the United States after living permanently outside of the U.S.
 I returned to the United States on *(insert date)* _____.

None of these statements apply to me.*

*Please contact Network Health Insurance Corporation at 1-800-983-7587 or TTY 1-800-947-3529 to see if you are eligible to enroll. We are open Monday through Friday from 8 a.m. to 5 p.m.

Please check the box below if you would prefer us to send you information in larger print:

Larger print

Please contact Network Health Insurance Corporation at 1-800-983-7587 if you need information in another language or format than what is listed above. Our office hours are Monday through Friday from 8 a.m. to 5 p.m. TTY users should call 1-800-947-3529.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares. 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:

Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares 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 only be in 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

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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: November 15 – December 31, of every year), or under certain special circumstances.

Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares serves a specific service area. If I move out of the area that Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares 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 Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares 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 Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares 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, Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares and other services contained in my Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR NETWORK PLATINUMPLUS/PLATINUMPREMIER/PLATINUMSELECT OR NETWORKCARES 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 Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares, he/she may be paid based on my enrollment in Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares.

Release of Information: By joining this Medicare health plan, I acknowledge that Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Network PlatinumPlus/PlatinumPremier/PlatinumSelect or NetworkCares 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 by Network Health Insurance Corporation or by Medicare.

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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: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____