




Proposed Eff. Date ____/____/____ MM/DD/YEAR
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## Amerivantage Plan Enrollment Request

SECTION A: INFORMATION ABOUT YOU (PLEASE PRINT)																																											
I am applying for membership in the following plan (check one):																																											
<input type="checkbox"/> Classic+Rx Plan Plan ID: _____	<input type="checkbox"/> Balance+Rx Plan Plan ID: _____	<input type="checkbox"/> Choice+Rx Plan Plan ID: _____	<input type="checkbox"/> Specialty+Rx Plan Plan ID: _____																																								
LAST NAME (as it appears on Medicare Card)	FIRST NAME		MI																																								
PERMANENT RESIDENCE STREET ADDRESS	CITY	STATE	ZIP																																								
MAILING ADDRESS (if different)	CITY	STATE	ZIP																																								
E-MAIL ADDRESS:																																											
PHONE # (     )		COUNTY OF RESIDENCE																																									
DATE OF BIRTH ____/____/____ MM/DD/YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY # (optional information) _____ - _____ - _____																																									
PRIMARY CARE PROVIDER		PROVIDER PHONE #																																									
PROVIDER ADDRESS		AMERIGROUP PROVIDER #																																									
<p style="text-align: center;"><b>MEDICARE CARD 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> </ul> <p style="text-align: center;">-OR-</p> <ul style="list-style-type: none"> <li>Attach a copy of your Medicare card or your Medicare letter from the Social Security Administration or Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: red; color: white;"> <td colspan="2" style="text-align: center;"><b>MEDICARE</b></td> <td style="text-align: center;"></td> <td colspan="2" style="text-align: center;"><b>HEALTH INSURANCE</b></td> </tr> <tr style="background-color: blue; color: white;"> <td colspan="5" style="text-align: center;">SAMPLE COPY</td> </tr> <tr> <td colspan="5" style="padding: 5px;">NAME OF BENEFICIARY</td> </tr> <tr> <td colspan="3" style="padding: 5px;">MEDICARE CLAIM NUMBER</td> <td colspan="2" style="padding: 5px;">SEX</td> </tr> <tr> <td colspan="3" style="padding: 5px;">_____ - _____ - _____</td> <td colspan="2" style="padding: 5px;">_____</td> </tr> <tr> <td colspan="2" style="padding: 5px;">IS ENTITLED TO</td> <td colspan="3" style="padding: 5px;">EFFECTIVE DATE</td> </tr> <tr> <td style="padding: 5px;">HOSPITAL (PART A)</td> <td colspan="2" style="padding: 5px;">_____</td> <td colspan="2" style="padding: 5px;">_____</td> </tr> <tr> <td style="padding: 5px;">MEDICAL (PART B)</td> <td colspan="2" style="padding: 5px;">_____</td> <td colspan="2" style="padding: 5px;">_____</td> </tr> </table>		<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>		SAMPLE COPY					NAME OF BENEFICIARY					MEDICARE CLAIM NUMBER			SEX		_____ - _____ - _____			_____		IS ENTITLED TO		EFFECTIVE DATE			HOSPITAL (PART A)	_____		_____		MEDICAL (PART B)	_____		_____	
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MEDICAL (PART B)	_____		_____																																								

Name \_\_\_\_\_

Date \_\_\_\_\_

Do you have End Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No  If you answered "yes" to this question and you do not need regular dialysis any more or have had a successful kidney transplant, please attach a note or record from your doctor showing you do not need dialysis or have had a successful kidney transplant.		
If "yes", please list your other coverage and your identification (ID) numbers for this group:	Name of other coverage:	
	ID# for this coverage:	Group# for this coverage:
Have you received a letter from another insurance company that states you have drug coverage that is as good as Medicare's? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you enrolled in your state Medicaid or medical assistance program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please write name of program:	
	Please write your Medicaid #:	
If we determine that you owe a late enrollment penalty, how would you prefer to pay it? <input type="checkbox"/> By Mail Each Month <input type="checkbox"/> By Automatic Deduction from Your Social Security Card Each Month		
<b>SECTION B: OTHER IMPORTANT INFORMATION</b>		
Are you currently enrolled in another Medicare Advantage plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name:	
Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation or VA benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, please provide the following information:  Name of Insurance _____ Policy # _____ Effective Date ____/____/____ <div style="text-align: right;">MM/DD/YEAR</div>		
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No	If married, is your spouse working? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact Name:	Phone #: (     )	
Do you live in an institution such as a skilled nursing facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list facility below:		
Facility Name:	Facility Phone #: (     )	
Facility Address:	Admission Date: ____/____/____ <div style="text-align: right;">MM/DD/YEAR</div>	
I prefer to receive plan documents and materials in: <input type="checkbox"/> English <input type="checkbox"/> Other language:		

**STOP - PLEASE READ THIS IMPORTANT INFORMATION**

If you currently have health coverage from an employer or union, joining Amerivantage could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Amerivantage may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs?  Yes  No

If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form, or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE.

**SECTION C: STATEMENTS OF UNDERSTANDING**

By completing this enrollment application, I agree to the following:

Amerivantage is a Medicare Advantage plan and *has a contract with the Federal government*. I will need to keep my 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. 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.

Amerivantage serves a specific service area. If I move out of the area that Amerivantage 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 Amerivantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Amerivantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Amerivantage coverage begins, I must get all of my health care from Amerivantage, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Amerivantage and other services contained in my Amerivantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Amerivantage WILL PAY FOR THE SERVICES.**

*I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Amerivantage, he/she may be compensated based on my enrollment in Amerivantage.*

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

Name \_\_\_\_\_

Date \_\_\_\_\_

**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 health care operations. I also acknowledge that Amerivantage 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 behalf of the individual under the laws of the State where the individual resides) 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 Amerivantage or by Medicare.

Please enroll me in the Amerivantage Plan. I understand I must live in the Amerivantage service area.

I understand that my proposed effective date of coverage with Amerivantage will be \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM/DD/YEAR

I understand that my signature on this application means I have read and understand the contents of this entire application form. Please read your Evidence of Coverage document to know what rules you must follow to receive coverage with Amerivantage.

Signature of Applicant or Authorized Representative\*

Today's Date

Authorized Representative Address\*

Phone Number\*

Signature of Person Assisting Applicant in Completing This Form

Date

Relationship to Applicant

\* If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by State law, or another person who is authorized by State law, must sign above. Attach a copy of proof of Legal Guardian status, other written proof of legal guardianship, DPAHC or proof of authorization under State law.

**FOR AMERIGROUP COMMUNITY CARE USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE**

SALES REPRESENTATIVE: \_\_\_\_\_ LEAD SOURCE: \_\_\_\_\_

ELECTION PERIOD:  AEP  OEP  SEP  ICEP

Applicant received copy of: Summary of Benefits  Yes  No Enrollment Application  Yes  No

White Copy – SSO Enrollment

Canary Copy – Sales Dept.

Pink Copy – Member

Retain Pink Copy for your records and for use as your temporary ID card.

## Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your 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.
- I recently move and this plan is a new option for me.*
- I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for Medicare prescription drugs.*
- I live in or *recently moved out of* a Long Term Care Facility (for example, a nursing home or long term care facility).
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (*coverage as good as Medicare's*).
- I am leaving employer or union coverage.
- 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.
- None of these statements applies to me\**

*\* Please contact AMERIGROUP Community Care at 1-866-805-4589. (TTY users should call 1-800-855-2880) to see if you are eligible to enroll. We are open seven days a week from 8 a.m. to 8 p.m. local time.*

AMERIGROUP is a culturally diverse company. We welcome all eligible individuals into our health care programs, regardless of health status. If you have questions or concerns, please call 1-866-805-4589 and ask for extension 34925. Or visit [www.myamerigroup.com](http://www.myamerigroup.com).