*i*Care Medicare Plan HMO SNP Enrollment Request Form

Please contact *i*Care Medicare Plan if you need information in another language or format (Braille).

To Enroll in *i*Care Medicare Plan, Please Provide the Following Information:			
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: ( )	Alternate Phone Number: ( )
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	State:	Zip Code	

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency contact:_____

Phone Number: _____ **Relationship to You:** _____

Email Address:

Please Provide Your Medicare Insurance Information

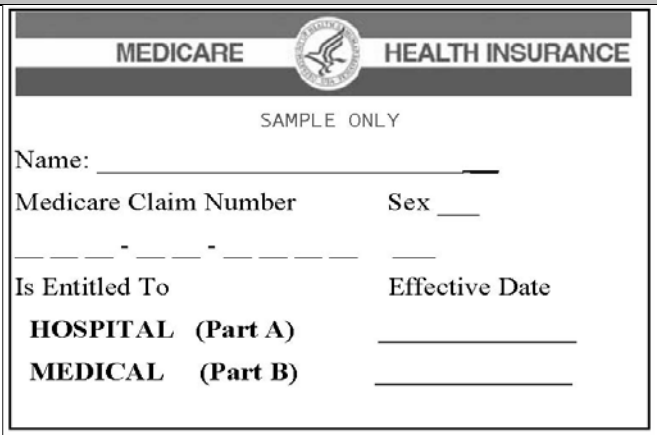
Please take out your Medicare card to complete this section.

- 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 such as *i*Care Medicare Plan.



Paying Your Plan Premium

If we determine that you owe a late enrollment penalty, (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Fund Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security 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 *i*Care 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 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 bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provider the following:

Account holder name:_____

Bank routing number:_____ Bank account number:_____

Account type: ___ Checking ___ Saving

☐ Credit Card. Please provide the following information:

Type of Card:_____

Name of Account holder as it appears on card:_____

Account number:_____

Expiration Date:_____/_____(MM/YYYY)

☐ 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 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 <u>prescription</u> drug coverage in addition to *i*Care Medicare Plan? ☐ **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**

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

____ Braille or large print

Please contact *i*Care Medicare Plan at 1-800-777-4376 if you need information in another format or language than what is listed above. Our office hours are 8:00 am to 8:00 pm, 7 days a week. 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 *i*Care Medicare Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join *i*Care Medicare 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.

*i*Care Medicare 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. 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.

*i*Care Medicare Plan serves a specific service area. If I move out of the area that *i*Care Medicare 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 *i*Care Medicare 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 *i*Care Medicare 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 *i*Care Medicare Plan coverage begins, I must get all of my health care from *i*Care Medicare Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by *i*Care Medicare Plan and other services contained in my *i*Care Medicare Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR *i*CARE MEDICARE 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 *i*Care Medicare Plan, he/she may be paid based on my enrollment in *i*Care Medicare Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that *i*Care Medicare Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that *i*Care Medicare 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:_____

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: _____

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-4376 (TTY: 1-800-947-3529).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-777-4376 (TTY: 1-800-947-3529).

iCare
INDEPENDENT CARE HEALTH PLAN
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212
www.icarehealthplan.org