Abrazo Advantage Health Plan (HMO)

Individual Enrollment Election Form

Please contact Abrazo Advantage Health Plan if you need information in another language or format.

Section I: To Enroll in Abrazo Advantage Health Plan, Please Provide the Following Information

Please check which plan you want to enroll in:
❑ Abrazo Advantage HMO - $25 per month ❑ Abrazo Advantage Plus HMO SNP - $0 per month

LAST Name:	FIRST Name:	Middle Initial	❑ Mr. ❑ Mrs. ❑ Ms.	Birth Date: (___/___/______) (MM/DD/YYYY)

Sex: ❑ M ❑ F	Home Phone No. ( )	Alternative Phone No. ( )	Email Address:

Permanent Residence Street Address (P.O. Box is not allowed):	City	State	Zip
Mailing/Billing Address (only if different from address above):	City	State	Zip

Section II: Please Provide Your Medicare Insurance Information

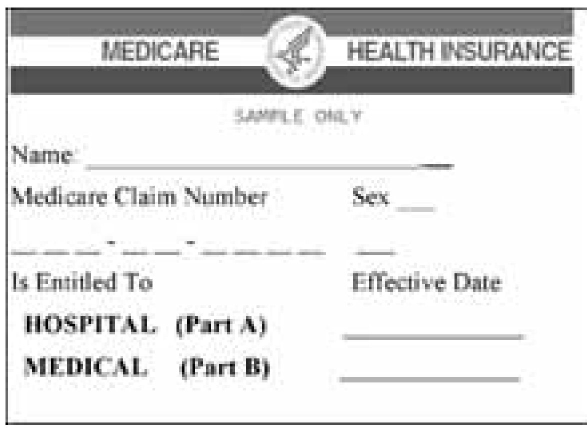
Please take out your Medicare card to complete this section.

- 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.



Section III: Paying Your Plan Premium

***If you are enrolling in our Abrazo Advantage Plus Plan:* 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, each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.**

***If you are enrolling in our Abrazo Advantage Plan:* You can pay your monthly plan premium by mailing a check, cashier's check, money order, traveler's check or credit card number each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month. Please choose one of the payment options below.**

Note: 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 (800) 772-1213. TTY users should call (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 premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please select a premium payment option: *You will receive a monthly bill for the amount due if no option is chosen.*

❑ Get a bill

❑ 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).

Section IV: 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 don't need dialysis or have had a successful kidney transplant.

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 Abrazo Advantage Health 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: ____________________

4. Are you enrolled in your State Medicaid (AHCCCS) program? ....❑ Yes ❑ No

   If yes, please provide your AHCCCS number: ______________________________

   To be eligible for Abrazo Advantage Plus you must be eligible for AHCCCS medical benefits.
   Do you have AHCCCS AND Medicare?........❑ Yes ❑ No

5. Do you or your spouse work?........❑ Yes ❑ No

Please provide the name of a Primary Care Physician:

Please check below if you would prefer us to send you information in a language other than English or in another format: ❑ Spanish ❑ Large Print

Please contact Abrazo Advantage Health Plan at (602) 824-3900 or (888) 864-1114 if you need information in another format or language. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY/TDD users should call (602) 824-3909 or (800) 489-1472 Monday-Friday, 8 a.m. to 5 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays.

Section V: Please Read This Important Information

If you currently have health coverage from an employer or union, joining Abrazo Advantage Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Abrazo Advantage Health 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section VI: Please Read and Sign Below

<u>If I am applying for Abrazo Advantage Plus, I agree to the following</u>:
Abrazo Advantage Plus is a Medicare Advantage Special Needs Plan with Prescription Drugs and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. To enroll and remain a member of Abrazo Advantage Plus, I also need to be eligible for AHCCCS medical benefits. If I lose my eligibility with AHCCCS, I will be disenrolled from Abrazo Advantage Plus. 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. Because I also qualify for AHCCCS, I can exercise my Special Enrollment Period and leave this plan at anytime throughout the year.

<u>If I am applying for Abrazo Advantage, I agree to the following</u>:
Abrazo Advantage 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: November 15-December 31 of every year), or under certain special circumstances.

<u>By applying for either plan listed above I agree to the following</u>:
Abrazo Advantage and Abrazo Advantage Plus serve specific areas. If I move out of the area that Abrazo Advantage or Abrazo Advantage Plus serve, 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 Abrazo Advantage or Abrazo Advantage Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Abrazo Advantage or Abrazo Advantage Plus 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 Abrazo Advantage or Abrazo Advantage Plus coverage begins; I must get all of my health care from Abrazo Advantage or Abrazo Advantage Plus except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Abrazo Advantage or Abrazo Advantage Plus and other services contained in my Abrazo Advantage or Abrazo Advantage Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ABRAZO ADVANTAGE OR ABRAZO ADVANTAGE PLUS WILL PAY FOR THE SERVICES.**

I understand that if I getting assistance from a sales agent, broker, or other individual employed by or contracted with Abrazo Advantage or Abrazo Advantage Plus, he/she may be paid based on my enrollment in Abrazo Advantage or Abrazo Advantage Plus.

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 state Medicaid program and the Medicare Savings Program.

<u>Release of Information</u>: By joining this Medicare health plan, I acknowledge that Abrazo Advantage 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 Abrazo Advantage Health 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 by Abrazo Advantage Health Plan or by Medicare.

Signature:				**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information:				
Name:	**Phone No.**	**Relationship to Enrollee:**		
Street Address:	**City:**		**State:**	**Zip:**

Section VII: 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. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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 AHCCCS 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 paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date): __________.
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (date): ______________________.
- ❑ I recently left a PACE program on (insert date): ______________________.
- ❑ I am leaving employer or union coverage 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 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 U.S. on (insert date): ______________.
- ❑ None of these statements applies to me*

* Please contact Abrazo Advantage Health Plan at (602) 824-3900 or (888) 864-1114 if outside of Maricopa County. TTY/TDD only, call (602) 824-3909 or (800) 489-1472 Monday-Friday, 8 a.m. to 5 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m.

For Office Use Only:

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

Plan ID: ______________________________

Effective Date of Coverage: __________ SEP (type): ❑ __________ ICEP/IEP: ❑ AEP: ❑ Not Eligible: ❑