

**Abrazo Advantage (HMO) Plan • Abrazo Advantage Plus (HMO) Plan**

**2010 Individual Enrollment Request Form**



7878 N. 16th Street, Suite 105  
Phoenix, AZ 85020  
[www.abrazoadvantage.com](http://www.abrazoadvantage.com)

*Member Services:*  
7 days a week, 8:00 a.m. to 8:00 p.m.  
(602) 824-3900 or (888) 864-1114

*Hearing Impaired Assistance TTY/TDD:*  
(602) 824-3909 or (800) 489-1472,  
Monday – Friday, 8:00 a.m. – 5:00 p.m.  
To access the Arizona Relay System call (800) 842-4681  
after hours, on weekends and holidays.



## Individual Election Form

### Completing the Application Process

Joining Abrazo Advantage Health Plan is easy. All you have to do is complete the enclosed application form by following the instructions. In general, completed and signed Individual Election Forms must be received by Abrazo Advantage Health Plan no later than the end of the month to be effective on the first of the next month.

If you are enrolling in Abrazo Advantage Plus (HMO), please be advised that it is a Medicare Advantage Special Needs Plan with Prescription Drugs. To qualify, an individual needs to have Medicare Parts A and B; be eligible for Medicaid (AHCCCS) medical benefits; and live in the Abrazo Advantage Health Plan service area- Maricopa or Pinal County.

If you are enrolling in Abrazo Advantage (HMO), you will need to have Medicare Parts A and B; and live in the Abrazo Advantage Health Plan service area- Maricopa or Pinal County.

1. Please complete the application using black ballpoint pen and press firmly. There are detailed instructions on the back cover. Please read the instructions and statements carefully. Complete one Individual Election Form per person. If you have any questions, please call Abrazo Advantage Health Plan at the telephone numbers listed on the back of this cover page.
2. Sign and date the election form upon completion. If you are the applicant's authorized representative (court appointed legal guardian, person having durable power of attorney for health care, or have the authority to act for the beneficiary in this capacity), please provide a copy of the authorizing paperwork with the application.
3. Return the completed form in the envelope included with your packet of information. Retain the last copy of your election form for your records. In most cases, we will acknowledge the receipt of your application in writing before the effective date.
4. If you do not receive your permanent membership card within 30 days of your effective date, you are to call Member Service 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, 8:00 a.m. to 5:00 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays). Hours are seven days a week 8:00 a.m. to 8:00 p.m.

**It's that simple to enroll in Abrazo Advantage Health Plan!**

### Important Information in Completing this Election Form

1. **NAME** – Please print your name exactly as it is written on your Medicare Health Insurance Card, even if there is an error. Errors need to be corrected with your local Social Security Administration Office. We will be notified of your corrected name by the Centers for Medicare and Medicaid Services (CMS) after SSA processes the correction.
2. **PRIMARY CARE PHYSICIAN** – Please select your Primary Care Physician (Family or Internal Medicine Practitioner) from the Provider Directory.
3. **MEDICARE CLAIM NUMBER** – Please print your Medicare Claim Number exactly as it is written on your Medicare Health Insurance Card. You must be entitled to Medicare Part A and enrolled in Medicare Part B to enroll in **Abrazo Advantage (HMO) or Abrazo Advantage Plus (HMO) Plan**. Please complete the effective dates of your Part A and B coverage on the form.
4. **MEDICAID (AHCCCS)** – To enroll in Abrazo Advantage Plus (HMO), you must be eligible for Medicaid (AHCCCS).
5. **END STAGE RENAL DISEASE (ESRD) INFORMATION** – Your election form will be considered incomplete and will not be processed if this question is not answered. If you have ESRD, you cannot enroll in this plan unless you are already enrolled in Phoenix Health Plan and developed ESRD while you were a member of that plan or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998. If you do not need regular dialysis anymore, or 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.
6. **UNDERSTANDING YOUR PLAN** – Read each statement carefully. If there is anything you do not understand, please do not hesitate to call Member Services 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, 8:00 a.m. to 5:00 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays). Hours are seven days a week 8:00 a.m. to 8:00 p.m.
7. **SIGNATURE** – By signing your election form, you agree to follow the plan rules and have an understanding of your member responsibilities. Sign your name as it is listed on your Medicare Health Insurance Card, and date the form. If someone has assisted you in completing this form, you both must sign and date the form and indicate your relationship. If you have any questions, please contact Abrazo Advantage Health Plan at the above mentioned telephone numbers for further instructions. Remember that your effective date is subject to approval by CMS. Upon confirmation from CMS, Abrazo Advantage Health Plan will send you written notice of your enrollment effective date.

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

**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) \$0 per month

LAST Name:                      FIRST Name:                      Middle Initial                       Mr.    Mrs.    Ms.

Birth Date: (____/____/____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (    )	Alternative Phone Number: (    )
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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:** \_\_\_\_\_


**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.

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

## Paying Your Plan Premium

### This Section Applies Only To Abrazo Advantage (HMO) 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**

*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](http://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.

If you don't select a payment option, you will get a bill each month.

#### **Please select a premium payment option:**

- Get a bill
- 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:**  
**This Section Applies to Abrazo Advantage (HMO) and Abrazo Advantage Plus (HMO)**

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 (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

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

**Please choose the name of a Primary Care Physician (PCP):**

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

Spanish

Please contact Abrazo Advantage Health Plan at 602-824-3900 or 1-888-864-1114 if you need information in another format or language than what is listed above. Our office hours are 7 days a week, 8:00 a.m. to 8:00 p.m. TTY/TDD users should call 602-824-3909 or 800-489-1472 Monday-Friday, 8:00 a.m. to 5:00 p.m. or call 800-842-4681 to access the Arizona Relay System after hours, on weekends and holidays.



**Please Read This Important Information**

**This Section Applies to Abrazo Advantage (HMO) and Abrazo Advantage Plus (HMO)**

**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 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:**

**This Section Applies to Abrazo Advantage (HMO) and Abrazo Advantage Plus (HMO)**

**If applying for Abrazo Advantage Plus (HMO) enrollment application, I agree to the following:**

Abrazo Advantage Plus (HMO) 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 (HMO), I also need to be eligible for Medicaid (AHCCCS) medical benefits. If I lose my eligibility with Medicaid, I will be disenrolled from Abrazo Advantage Plus (HMO). 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 Medicaid I can exercise my Special Enrollment Period and leave this plan at anytime throughout the year.

**If applying for Abrazo Advantage (HMO) enrollment application, I agree to the following:**

Abrazo Advantage (HMO) 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.

**By applying for Abrazo Advantage (HMO) or Abrazo Advantage Plus (HMO) I agree to the following:**

Abrazo Advantage (HMO) and Abrazo Advantage Plus (HMO) Plans serve specific service areas. If I move out of the area that Abrazo Advantage (HMO) and Abrazo Advantage Plus (HMO) 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 Abrazo Advantage (HMO) or Abrazo Advantage Plus (HMO), 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 (HMO) or Abrazo Advantage Plus (HMO) when I get it to know which rules I must follow in order to receive 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 (HMO) or Abrazo Advantage Plus (HMO) coverage begins; I must get all of my health care from Abrazo Advantage (HMO) or Abrazo Advantage Plus (HMO) except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Abrazo Advantage (HMO) or Abrazo Advantage Plus (HMO) and other services contained in my Abrazo Advantage (HMO) or Abrazo Advantage Plus (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ABRAZO ADVANTAGE (HMO) OR ABRAZO ADVANTAGE PLUS (HMO) 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 Abrazo Advantage Health Plan, he/she may be paid based on my enrollment in Abrazo Advantage (HMO) or Abrazo Advantage Plus (HMO).

**Release of Information:** 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:** \_\_\_\_\_ **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:* \_\_\_\_\_

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 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 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 (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 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, 8:00 a.m. to 5:00 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, 8:00 a.m. to 8:00 p.m.