Enrollment Application

Coverage Effective Date _____

You may not select your effective date of coverage. Citizens Choice Healthplan (CCHP) HMO will formally notify you when you may begin using plan services.

❑ LA ❑ OC ❑ SB ❑ RV

Tell Us About Yourself (Please Print)

Name As It Appears On Your Medicare Card (Last)	(First)	(M.I.)
Permanent Residence Address	City	Zip Code
Mailing Address (If different from above)	City	Zip Code

Home Telephone Number	Sex	Birthday (MM/DD/YY)	Your E-mail Address (Optional)
Your Medicare Number (As it appears on your Medicare Card)		Personal Primary Care Physician/I.D. Number	

I Am Entitled To:	You Can Verify Your Benefits By:
❑ Hospital Insurance Benefits (Part A) Date _____	❑ Medicare Card
❑ Medical Insurance Benefits (Part B) Date _____	❑ SSA Letter Date _____

What Is Your Primary Language? (Check One)

❑ English ❑ Spanish ❑ Other _____

How would you prefer to receive your member information: ❑ Print ❑ E-mail ❑ CD ❑ Website

Please contact CCHP HMO at 1-866-634-2247 if you need information in another format or language than what is listed above. Our office hours are Monday - Sunday, 8:00 a.m. - 8:00 p.m. TTY users should call 1-866-516-9366.

Check either **Yes** or **No** to each question:

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. Are you a resident in a long-term care facility, such as a nursing home?..... ❑ Yes ❑ No
   If yes, name of institution _____ Telephone number of institution _____
   Address of institution (number and street) _____

3. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceuticals assistance programs.
   Will you have other prescription drug coverage in addition to CCHP HMO? ..... ❑ Yes ❑ No
   If "Yes" please list your coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage _____
   Group # for this coverage _____ ID # for this coverage _____

4. Are you enrolled in your State Medicaid Program (Medi-Cal)?..... ❑ Yes ❑ No
   If yes, please provide your Medi-Cal Number _____

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

6. I understand that by selecting my Personal Primary Care Physician I am also selecting the physician group, hospitals and specialists associated with my Personal Primary Care Physician. ..... ❑ Yes ❑ No

7. Have you been given a CCHP HMO Summary of Benefits and Provider Directory? ..... ❑ Yes ❑ No

Late Enrollment Penalty Premium Information:

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 each, month. You can also choose to pay your premium by automatic deduction from your Social 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 CCHP HMO 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% of 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/TDD 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 late enrollment premium payment option:

❑ Get a bill

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

STOP Please Read This Important Information

If you currently have health coverage from an employer or union, joining Citizens Choice Healthplan (CCHP) HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CCHP HMO. 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:

CCHP HMO 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. 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: October 15 – December 7 of every year), or under certain special circumstances.

CCHP HMO serves a specific service area. If I move out of the area that CCHP 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 CCHP HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from CCHP HMO 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 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 CCHP HMO coverage begins, I must get all of my health care from CCHP HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by CCHP HMO and other services contained in my CCHP HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR CCHP 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 CCHP HMO, he/she may be paid based on my enrollment in CCHP HMO.

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

Address _____ Relationship to Enrollee _____

Name of Emergency Contact _____ Emergency Contact E-Mail _____

Emergency Contact Telephone Number _____ Relationship to Enrollee _____

Name of Sales Representative (if assisted with Enrollment): Rick Plata

Enrolling Sales Representative's Signature _____ Sales #ID _____

Print Name Rick Plata Date _____

Office Use Only:

ICEP/IEP: _____ AEP: _____ SEP(Type): _____ Not Eligible: _____

Please mail your completed form to:

Medicare Options

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060.