2012 MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

Health Net®
MEDICARE PROGRAMS

Please contact Health Net if you need information in another language or format (Braille).

To Enroll in Health Net, Please Provide the Following Information:	
Please check which plan you want to enroll in:	
Health Net Healthy Heart (HMO) (includes prescription drug coverage)	
☐ Alameda	$129 per month
☐ Contra Costa, Fresno	$69 per month
☐ San Diego	$0 per month
☐ San Francisco	$99 per month
☐ San Joaquin, San Mateo, Solano	$133 per month
☐ Santa Clara	$119 per month
☐ Sonoma, Stanislaus	$135 per month
☐ Yolo	$109 per month
Health Net Healthy Heart Plan 1 (HMO) (includes prescription drug coverage)	
☐ Los Angeles, Orange, Riverside, San Bernardino	$0 per month
☐ Placer, Sacramento	$79 per month
Health Net Healthy Heart Plan 2 (HMO) (includes prescription drug coverage)	
☐ Los Angeles, Orange, Riverside, San Bernardino, San Diego	$20 per month
☐ Placer, Sacramento	$129 per month
Salud con Health Net Medicare Advantage (HMO) (includes prescription drug coverage)	
☐ Los Angeles, Orange, Riverside, San Bernardino	$0 per month
Health Net Seniority Plus Green (HMO) (does not include prescription drug coverage)	
☐ Alameda, Contra Costa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Yolo	$89 per month
☐ Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego	$0 per month
Health Net Seniority Plus Ruby (HMO) (includes prescription drug coverage)	
☐ Kern	$0 per month
☐ San Diego, Santa Barbara, Santa Cruz	$192 per month
☐ Santa Clara	$69 per month
☐ San Joaquin	$29 per month
Health Net Seniority Plus Ruby Plan 1 (HMO) (includes prescription drug coverage)	
☐ Los Angeles, Orange, Riverside, San Bernardino	$0 per month
Health Net Seniority Plus Ruby Plan 2 (HMO) (includes prescription drug coverage)	
☐ San Diego	$69 per month

(continued on next page)

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To Enroll in Health Net, Please Provide the Following Information (continued):

Health Net Seniority Plus Amber CHF (HMO SNP)[1] (Congestive Heart Failure) (includes prescription drug coverage)

☐ Riverside, San Bernardino — $0 per month

Health Net Seniority Plus Amber I (HMO SNP)[1] (All Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

☐ Kern, Los Angeles, Orange, Riverside, San Bernardino — $25.80* per month

Health Net Seniority Plus Amber II (HMO SNP)[1] (Full Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

☐ Alameda, Contra Costa, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco — $30.90* per month

*actual premium based on Low Income Subsidy status

Health Net Violet (PPO) (includes prescription drug coverage)

☐ Contra Costa — $30 per month

☐ Sacramento — $0 per month

☐ San Diego — $62 per month

[1]You must meet specific enrollment criteria to enroll in this plan.

Please check if you would like to enroll in Optional Supplemental Benefits for an additional monthly premium:

☐ Optional Supplemental Package #1 $19 per month

☐ Optional Supplemental Package #2 $29 per month

☐ Optional Supplemental Package #3 $17 per month

☐ Optional Supplemental Package #4 $27 per month

☐ Optional Supplemental Package #5 $27 per month

Monthly Plan Premium Amount (including optional supplemental package premium amount)

$_____ Requested Effective Date: __ __/__ __/__ __ __ __

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**:_____

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.

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying Your Plan Premium

For all plans with no 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 or Electronic Funds Transfer (EFT) 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 Health Net the Part D-IRMAA.

For all plans with premium: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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 RRB. DO NOT pay Health Net 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 provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

☐ 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.)

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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 prescription drug coverage in addition to Health Net? ☐ 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

6. Do you have Congestive Heart Failure (CHF)? ☐ Yes ☐ No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:
_____

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:

☐ Spanish ☐ Chinese ☐ Large Print ☐ Other: _____

Please contact Health Net at 1-800-977-6738 for Seniority Plus, Healthy Heart and Salud con Health Net Medicare Advantage, or 1-800-579-9096 for Health Net Violet, if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week. TTY users should call 1-800-929-9955.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Health Net could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Net. 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:

Health Net of California, Inc. (HNCA) and Health Net Life Insurance Company (HNL) are Medicare Advantage plans and have 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.

Health Net serves a specific service area. If I move out of the area that Health Net 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 Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net 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 Health Net coverage begins, I must get all of my health care from Health Net, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net and other services contained in my Health Net Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

I understand that beginning on the date Health Net Violet coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Health Net provides refunds for all covered benefits, even if I get services out of network. Services authorized by Health Net and other services contained in my Health Net Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET 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 Health Net, he/she may be paid based on my enrollment in Health Net.

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

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AGENT/SALES REP OFFICE USE ONLY

Required: Broker/Sales Rep Information

Broker Name: Rick Plata Phone #: 888-235-8060 ID #: AF136

Sales Rep Name: _____ Phone #: _____ ID #: _____

FMO/GA/Agency Name: _____ Phone #: _____ ID #: _____

Broker/Sales Rep Received Date: __ __/__ __/__ __ __ __

Broker Email Address: advisorrick@msn.com

Health Net Enrollment Office Use Only:

Effective Date of Coverage: _____ Plan/Group ID: _____

PCP Code: _____ and PPG Code: _____ or POC: _____

Election Period (check one):

ICEP/IEP: ____ AEP: ____ SEP (type): _____ Not Eligible _____

6025432 CA78449 (8/11)

White – Health Net Yellow – Writing Agent Pink – Member

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 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 recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. 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.
☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact Health Net at 1-800-977-6738 for Seniority Plus, Healthy Heart and Salud con Health Net Medicare Advantage or 1-800-579-9096 for Health Net Violet (TTY users should call 1-800-929-9955) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., 7 days a week.

Health Net Medicare Advantage

2012 Statement *of* Understanding *for Sales Appointments*

Health Net®
MEDICARE PROGRAMS

Medicare beneficiary should initial each box confirming that the sales agent has reviewed each item listed below, and that the beneficiary understands this important enrollment information.

Initial each box after reviewing	
	Health Net Representative/Agent 1. The person that is discussing Medicare health plan options with me does not represent Medicare, Social Security Administration or any branch of the federal or state government.
	Medicare Advantage vs. Medicare Supplement 2. I understand that the Health Net Medicare Advantage (HMO/PPO/SNP) health plan _____ (print plan name) I have selected is not a Medicare Supplemental plan. Health Net will be responsible for my covered medical services and/or prescription drugs. I will use my Health Net ID card rather than my white, red and blue Medicare card to access my coverage.
	Medicare Advantage Plan Change 3. When enrolling in a Health Net Medicare Advantage Plan, I understand that I will be automatically disenrolled from any other Medicare Advantage or Part D plan. I understand that I can only be enrolled in one Medicare Advantage plan at a time.
	Other Coverage 4. I must cancel any existing employer group or Medicare Supplement coverage when enrolling in a Health Net Medicare Advantage Plan. I understand that I cannot be enrolled in a Medicare Supplement plan and a Medicare Advantage plan or an employer group plan at the same time.
	Doctor(s) Selection 5. I understand that I must disclose all doctors providing my health care, including specialists, mental health providers and hospitals in order for my Health Net Representative/Agent to accurately confirm if my doctors are in-network providers who contract with Health Net. If enrolling in an HMO, I have also selected my primary care physician (PCP) _____(print physician name) to coordinate all of my medical services within my primary care medical group (PCMG) for an effective date of _____(print date).
	Doctor Network and Referral 6. If enrolling in an HMO, I must use Health Net contracted physicians, medical groups, hospitals and other providers, and most services may require a referral or authorization prior to the service being provided. In most cases, if routine care is obtained from out-of-network providers, neither Medicare nor Health Net will be responsible for the costs associated with the care unless the care has been prior authorized by Health Net. I understand the physician's contractual relationship with Health Net is subject to change at any time and I will be notified in writing by the company. If enrolling in a PPO, I understand that when I obtain services from out-of-network providers, I may pay higher copays or coinsurance than when I obtain services from in-network providers.
	Legal or Other Representative Assistance 7. I attest there is no other legal representative or power of attorney (POA) or other individual(s) that need to be present to assist me with my health care decisions. If I do not have legal or other representative assistance, then this question is not applicable (N/A).

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White – Writing Agent Pink – Enrollee

	Medicare and Medicaid or Medi-Cal Coverage 8. **Dual Eligible Special Needs Plan (DE-SNP) Enrollees Only (If available in your area):** I have been informed by my Health Net Representative/Agent that by enrolling in Health Net's Amber HMO Special Needs Plan (SNP), Health Net will be responsible for my covered medical services and/or prescription drugs. I will present both my Health Net ID card and Medicaid/ Medi-Cal card to obtain my health care and prescription drug coverage. Health Net is my primary insurer and Medicaid/Medi-Cal provides secondary coverage for some items/services not covered by Health Net. I must contact my primary care provider (PCP) to coordinate all my medical services with Health Net within my participating provider group (PPG). Once enrolled, I will be automatically disenrolled from any stand-alone Prescription Drug Plan coverage.
	Health Net Representative/Agent Requirements 9. The Health Net Representative/Agent has: a. Reviewed the summary of benefits and other required information in the enrollment packet with me in a language which I comprehend and understand. I am comfortable enrolling in the plan. b. Informed me of the timeframes that I may enroll or disenroll in Medicare Advantage plans, (i.e., Annual Election Period, Annual Disenrollment Period and Lock-in periods). c. Designated the primary care provider (PCP) and primary care medical group (PCMG) accurately on the enrollment form, if I am enrolling in an HMO. d. Provided me with his or her business card with a business phone number should I have additional questions. e. Provided me with a copy of the completed application, all required materials, and a copy of this form. f. Verbally explained how or where to find out which prescription drugs are covered, explained prescription drug pricing (including where to look up prescription drug pricing), and described the prescription drug coverage gap or "donut hole" or where to find it's description. g. Discussed the Optional Supplemental Benefit packages with me, including the covered benefits, non-covered benefits, copayments and premiums if available with my plan.

Enrollee statement: By signing this form, I certify that my Health Net Representative/Agent has reviewed this information with me, and the information I have supplied to the Health Net Representative/Agent has been accurately recorded here.

Enrollee's name: Last:	First:	MI:	Medicare #: __ __ __ – __ __ – __ __ __ __ __
Enrollee phone #: (__ __ __) __ __ __–__ __ __ __	Plan selected:		
Legal representative name (or N/A):		Legal rep phone #: (__ __ __) __ __ __–__ __ __ __	
Enrollee's or legal representative's signature:		Date: (__ __/ __ __/ __ __ __ __) (M M D D Y Y Y Y)	
Health Net Representative/Agent statement: I certify that I have reviewed this document, the summary of benefits for the selected product, and other Health Net or CMS required information with the enrollee; that the information on the application has been provided to me by the enrollee and/or their legal representative; and that the enrollee or legal representative has signed the enrollment application.			
Health Net Representative/Agent name:		Health Net Representative/Agent signature:	
Health Net Representative/Agent #:		Date: (__ __/ __ __/ __ __ __ __) (M M D D Y Y Y Y)	

Health Net Representative/Agent:
You must provide a copy of this form to the Medicare beneficiary.
It is not necessary to submit a copy of this form along with the enrollment application.
Please keep a copy for your records and provide a completed copy upon request.

Health Net. A Medicare Advantage organization with a Medicare contract. A stand-alone prescription drug plan with a Medicare contract. A Coordinated Care plan with a Medicare Advantage contract but without a contract with the state Medicaid program. This contract is renewed annually, and availability of coverage beyond the end of the contract year is not guaranteed. This plan may not be available to Medicare beneficiaries in the following contract year because by law, plan sponsors, like Health Net, can choose not to renew their contract with CMS, or they can reduce their service area, and CMS may also refuse to renew the contract, thus resulting in a termination or non-renewal. Individuals must have both Part A and Part B to enroll. You must reside in the plan service area in order to apply for Health Net's Medicare Advantage (MA) plans. Medicare beneficiaries can only enroll in these plans during certain times of the year and must continue to pay their Medicare Part B premiums. Eligible beneficiaries must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances, and quantity limitations and restrictions may apply. Limitations, copayments/coinsurance and restrictions may apply. Plan benefits and cost-sharing may vary by plan, county and region. For (Amber) Dual Eligible SNP enrollees: Premiums, copayments, coinsurance and deductibles may vary based on the level of extra help received. Contact the plan for further details. This plan is available to anyone who has both Medical Assistance from the State and Medicare. For (Jade) Chronic SNP enrollees: This plan is available to all people with Medicare who have been diagnosed with Congestive Heart Failure (CHF) and/or Diabetes.

In-network providers are those providers who contract with Health Net. Out-of-network providers are those who do not have a contract with Health Net but who do accept Medicare. You must use plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers, you may be required to get prior-authorization or to be referred by your primary care physician for services outside your primary care physician or medical group. If a referral or a prior-authorization is required and has not been obtained, you may have to pay for these services yourself.

Medicare beneficiaries may enroll in Health Net's MA plans through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at www.Medicare.gov. For full information on this plan's benefits, including information on premium withhold or direct bill options, and other exclusions, limitations or restrictions to services not already identified in this document, please contact Health Net at 1-800-275-4737 in California, 1-888-445-8913 in Oregon (TTY 1-800-929-9955 for the hearing impaired), 8:00 a.m. to 8:00 p.m., 7 days a week.

This information is available for free in other languages. Please contact our customer service number at 1-800-275-4737 for additional information. Our hours of operation are 8:00 a.m. to 8:00 p.m., seven days a week. TTY/TDD users call 1-800-929-9955.

Esta información está disponible en forma gratuita en otros idiomas. Comuníquese con el número de nuestro servicio al cliente al 1-800-275-4737 para obtener información adicional. Nuestro horario de atención es de 8:00 a.m. a 8:00 p.m., los siete días de la semana. Los usuarios de TTY/TDD deben llamar al 1-800-929-9955.

本資訊備有其他語言版本，可免費提供。請致電 1-800-275-4737 向我們的客戶
服務部查詢其他資訊。每週 7 天，每天上午 8:00 到下午 8:00 均提供服務。
聽 / 語障人士請致電 1-800-929-9955。

CA80982-1 (5/11)

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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.