MD Care Healthplan (HMO)
Doctors Making the Decisions

MD Care Health Plan (HMO)
P.O. Box 92919
Long Beach, CA 90809
Telephone: 1.888.322.2730
TTY 1.800.735.2929

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

To Enroll in MD Care Health Plan (HMO), Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ **ADVANTAGE I** (MA-PD)
Includes medical and prescription drug benefits.

☐ **ADVANTAGE SELECT** (MA-Only)
Includes medical benefits (no Part D prescription drug benefits).

☐ **PREFERRED DUAL** (SNP)
Special Needs Plan (SNP) Includes medical and prescription drug benefits for full dual beneficiaries. This plan is available to any one who has both Medical Assistance from the State - Full Medi-Cal and Medicare.

LAST Name:	FIRST Name:	MI:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M/ D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home 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: ____

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 or blue Medicare card;

– OR –

- Attach a copy of your Medicare card or your letter from the Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

Name: ____

Medicare Claim Number Sex ____

___ ___ ___- ___ ___ - ___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) ____

MEDICAL (Part B) ____

WHITE–Processing Individual YELLOW–MD Care, Inc. Representative PINK–Enrolling Individual

Paying your Plan Premium

If you are joining **Advantage I** and 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, Personal Check, Money Order or Cashier's Check each month.

You can also choose to pay your late enrollment penalty 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 MD Care Health Plan 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 don't select a payment option, you will get a bill each month.

Please select a late enrollment penalty 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 late penalties due from your enrollment effective date up to the point witholding 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.)

Please Read and Answer the Following 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 MD Care 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 (Medi-Cal)? ☐ Yes ☐ No

If yes, please provide your Medicaid number: ______________________________

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

Please choose a Primary Care Physician (PCP) and an IPA or Medical Group affiliated with (PCP):

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:

Language(s): ☐ Spanish ☐ Other: ______________________________

Format(s): ☐ Large Print ☐ Braille

Please contact MD Care Health Plan at (888) 285-9676, if you need information in another format or language than what is listed above. From October 15th to March 1st, our call center hours are from 8:00 AM to 8:00 PM seven days a week. After March 2nd, our call center hours are from 8:00 AM to 8:00 PM Monday through Friday. TTY Users should call (800) 735-2929.

Please Read This Important Information

If you currently have health care coverage from an employer or union, joining MD Care Health Plan could affect your employer or union health benefits. *You could lose your employer or union health coverage if you join MD Care 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 employer's or union's 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:

MD Care Health 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. If I join **Advantage Select** and 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.

MD Care Health Plan serves a specific service area. If I move out of the area that MD Care Health 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 MD Care Health

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

Release of Information: By joining this Medicare health plan, I acknowledge that MD Care 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 MD Care 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 from Medicare.

Your 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): Rick Plata

Agent ID # 320006 Agency/Brokerage: Green Leaf

Effective Date of Coverage: __________ Plan ID #: __________

ICEP/IEP: ______ AEP: ______ SEP (type): ______ Not Eligible: __________

WHITE–Processing Individual YELLOW–MD Care, Inc. Representative PINK–Enrolling Individual

H7731_2012_Enrollment Form CMS Approved 09302011

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person

Please initial below beside the type of product(s) you want the agent to discuss.

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) —A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Please note: When a beneficiary enrolls in a plan, he/she agrees to use the network of physicians, hospitals, and providers that are affiliated with the plan for all health care services, except emergencies, urgently needed care, or out-of-area renal dialysis services.

By signing this form, you agree to a meeting with a sales agent to discuss the type of products you initialed above. Please note, the person who will discuss the proucts is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

____

Signature:

____

Signature Date:

If you are the authorized representative, please sign above and print below:

Representative'sName:____

Your Relationship to the Beneficiary: ____________________________________

To be completed by Agent:

Agent Name: Rick Plata	Agent Phone: 888-235-8060
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
[Plan Use Only:]	

*Scope of Appointment documentation is subject to CMS record retention requirements *

A Medicare Advantage Organization with a Medicare Contract

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.