SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Please contact Sierra Spectrum (PPO) or Sierra Nevada Spectrum (Regional PPO) if you need information in another language or format (Braille).

**To enroll in Sierra Spectrum or Sierra Nevada Spectrum, please provide the following information**

**Please check which plan you want to enroll in:**

| | | |
|---|---|---|
| ☐ Sierra Spectrum (PPO) | MAPD H2905-001 | $0 per month |
| ☐ Sierra Nevada Spectrum (Regional PPO) | MAPD R5674-001 | $0 per month |

| **Last Name** | **First Name** | **Middle Initial** | ☐ Mr. ☐ Mrs. ☐ Ms. |
|---|---|---|---|
| Birth Date<br>(______ / ______ / ____________)<br>(MM / DD / YYYY) | Sex<br>☐ M ☐ F | Home Phone Number<br>(          ) | Alternate Phone Number (Optional)<br>(          ) |

Permanent Residence Street Address (P.O. Box is not allowed)

| City | County (Optional) | State | ZIP Code |
|---|---|---|---|

Mailing Address (only if different from your Permanent Residence Address)

| City | State | ZIP Code |
|---|---|---|

Emergency Contact (optional)

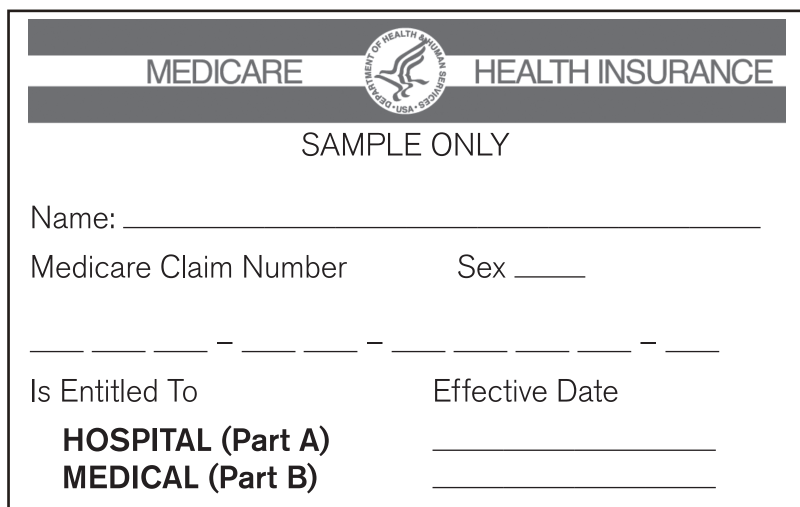
| Phone Number (optional)<br>(          ) | Relationship to You (optional) |
|---|---|

Email Address (optional)

**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 the Social Security or the Railroad Retirement Board




➔ **You must have Medicare Part A and Part B to join a Medicare Advantage plan.**

## Paying your plan 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 Sierra Spectrum/Sierra Nevada Spectrum, 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 ☐ Savings

☐ **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.)

## 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 Sierra Spectrum/Sierra Nevada Spectrum?
   ☐ 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

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

**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 ☐ Visually impaired audio assistance

Please contact Sierra Spectrum/Sierra Nevada Spectrum, at 1-877-271-8591 if you need information in another format or language than what is listed above. **Our office hours are October 15, 2011 through February 14, 2012:** 8 a.m. to 8 p.m. local time, 7 days a week. **February 15, 2012 through October 14, 2012:** Monday – Friday from 8 a.m. to 8 p.m. local time. TTY users should call 711.

**STOP – Please read this important information**

**If you currently have health coverage from an employer or union, joining Sierra Spectrum/ Sierra Nevada Spectrum could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Sierra Spectrum or Sierra Nevada Spectrum.** 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:**
Sierra Spectrum/Sierra Nevada Spectrum 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.

Sierra Spectrum/Sierra Nevada Spectrum serves a specific service area. If I move out of the area that Sierra Spectrum/Sierra Nevada Spectrum 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 Sierra Spectrum/Sierra Nevada Spectrum, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Sierra Spectrum/Sierra Nevada Spectrum 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 Sierra Spectrum/Sierra Nevada Spectrum 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, Sierra Spectrum/Sierra Nevada Spectrum provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Sierra Spectrum/Sierra Nevada Spectrum and other services contained in my Sierra Spectrum/Sierra Nevada Spectrum Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SIERRA SPECTRUM OR SIERRA NEVADA SPECTRUM 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 Sierra Spectrum/Sierra Nevada Spectrum, he/she may be paid based on my enrollment in Sierra Spectrum/Sierra Nevada Spectrum.

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

**Office use only:**

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

| Plan ID#: | Effective Date of Coverage: |
|---|---|

ICEP/IEP: ____________ AEP: ____________ SEP (type): ____________ Not Eligible: ____________

This information is available for free in other languages. Please contact our Customer Service number at 1-877-271-8591 for additional information, TTY: 711.

Esta información está disponible en otros idiomas sin costo. Para obtener información más detallada, comuníquese con nuestro Servicio al Cliente llamando al 1-877-271-8591, TTY: 711 (servicio para personas con problemas auditivos y del habla).

## 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 other 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 Sierra Spectrum (PPO) or Sierra Nevada Spectrum (RPPO) at 1-877-271-8591 (TTY users should call 711) to see if you are eligible to enroll. From March 2, 2011 through October 14, 2011, we are open Monday – Friday from 8 a.m. to 8 p.m. From October 15, 2011 through February 14, 2012, we are open from 8 a.m. to 8 p.m., seven days a week. From February 15, 2012 through October 14, 2012, we are open Monday – Friday from 8 a.m. to 8 p.m. Calls on Saturday, Sunday and holidays will be received by our automated phone system (where you can leave a detailed message and a representative will return your call as soon as possible).

Name ______________________________ Date ____________________

Medicare Claim Number ______________________________

SIERRA Spectrum®
PPO Plan
a product of Sierra Health and Life Insurance Company, Inc.®

SIERRA NEVADA Spectrum℠
Regional PPO Plan
a product of Sierra Health and Life Insurance Company, Inc.®

## Agent/enrollee confirmation checklist

| Enrollee's name: | Enrollee's date of birth: |
|---|---|
| Enrollee's Medicare/HIC#: | |

| ✓ | **Please indicate a check mark in the column to the left of each statement to attest that each concept has been reviewed with the enrollee.** |
|---|---|
| | The enrollee understands that I (the agent) am either employed by or contracted with Sierra Health and Life and may be paid based on the enrollee's enrollment in this plan. |
| | The enrollee is entitled to Medicare Parts A and enrolled in Part B. I (the Agent) verified entitlement and enrollment. |
| | The enrollee understands this is a Preferred Provider Organization (PPO) plan. The enrollee understands that if a member chooses to see network providers, their costs for services will generally be less and they have the comfort of knowing that they have selected a physician: (1) whose credentials are periodically checked by the plan; (2) who has a contract to provide certain specified services; (3) who must meet certain access requirements and quality standards for care; and (4) who will bill the PPO directly and reduce paper work. Members can also opt to see doctors that do not belong to the PPO provider network. The enrollee understands that if a member chooses to see out-of-network providers, the costs are generally higher. |
| | The enrollee understands that they will receive a verification call to confirm their desire to enroll in the plan and to confirm their understanding of the plan rules. I have verified that:<br>The best telephone number to call is ______________________ .<br>The best time of day/night to call is ______________________ . |
| | The enrollee understands that there is no monthly plan premium for Sierra Nevada Spectrum or Sierra Spectrum, however, the member must continue to pay their Medicare Part B premiums and Part A premiums, if applicable. |
| | The enrollee understands that his/her enrollment is not effective until eligibility has been verified by Medicare. |
| | The enrollee understands that he/she will be automatically disenrolled from any other Medicare health plan that he/she is currently enrolled in once this enrollment has been confirmed by Medicare and they are enrolled in this plan. |

| **AGENT ATTESTATION** | | **ENROLLEE ATTESTATION** |
|---|---|---|
| I (the Agent) have explained the eligibility provisions to the enrollee. I have not made any statements about benefits, conditions or limitations of the agreement except through written material furnished by the plan. I certify that the information supplied to me by the enrollee has been truly and accurately recorded. | | I (the enrollee) have had the eligibility provisions and plan rules explained to me. My signature below means that I have understood this information and want to be enrolled in this plan. The information I provided to the agent and on the enrollment form is correct to the best of my knowledge. |
| Agent name (please print) Rick Plata | | Enrollee name (please print) |
| Agent signature/date | | Enrollee signature/date |
| Agent number 2066024 | Agency name | **Thank you!** |

**Please attach to the enrollment form (keep a copy for your records).**

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UHEX12MP3350140_000 PD 992 (9/11) 
WHITE – COMPANY COPY CANARY – COMPANY COPY PINK – CUSTOMER COPY

# 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.