



# Medicare Advantage Health Plans Enrollment Application & Part D Application EMPLOYER GROUP

**By completing this enrollment application, I agree to the following:**

MVP 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.**

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 through my employer group.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP 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 MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP 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 MVP coverage begins, I must get all of my health care

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

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).



Please complete all three pages. Complete one enrollment form per applicant.

Section 1: Plan Enrollment Selection for Employer Group or Union Members

Employer or union name \_\_\_\_\_ Group # \_\_\_\_\_

Please check which plan you want to enroll in:

- Preferred Gold HMO with MVP Part D Prescription Drug
GoldAnywhere PPO with MVP Part D Prescription Drug
Preferred Gold HMO without MVP Part D Prescription Drug

Section 2: Member Information

LAST Name \_\_\_\_\_ FIRST Name \_\_\_\_\_ Mid. Init. \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ County \_\_\_\_\_

Home Phone Number ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gender: Male Female

Mailing Address (if different from permanent address — include number, street, and apt. #) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ County \_\_\_\_\_

Section 3: Medicare Card 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 Administration or the Railroad Retirement Board.

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

Medicare Health Insurance

Name \_\_\_\_\_

Medicare Claim # [ ] [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ] [ ] [ ]

Is Entitled To: Hospital (Part A) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Medical (Part B) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Section 4: Primary Care Physician (PCP) – not required for GoldAnywhere PPO**

Primary Care Physician (*full name required*) \_\_\_\_\_

Address \_\_\_\_\_

Existing patient?     Yes     No

**Section 5: Please read and answer the following questions**

1. Are you the retiree?  Yes     No

If yes, retirement date (*month/day/year*) \_\_\_\_\_ If no, name of retiree \_\_\_\_\_

2. Are you covering a spouse or dependents under this employer or union plan?  Yes     No

If yes, name of spouse \_\_\_\_\_

Names of dependents \_\_\_\_\_

3. Do you or your spouse work?  Yes     No

4. 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 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.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs (EPIC).

Will you have other prescription drug coverage in addition to MVP?  Yes     No

If yes, name of other coverage \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Your answer to the following question will not keep you from enrolling in this plan.**

6. 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): \_\_\_\_\_

\_\_\_\_\_

## Section 6: Signature and Authorization

**Release of information:** By joining this Medicare health plan, I acknowledge that the Medicare 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 MVP 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 MVP or by Medicare.

### PLEASE SIGN BELOW

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 \_\_\_\_\_

**Please contact MVP if you need information in another language or format (Braille).**

### For Office Use Only

**Enter in:**

**Amisys**

**Facets**

If current member, please include member ID number:

A \_\_\_\_\_

OR

800 \_\_\_\_\_

Previous ID # \_\_\_\_\_ Group Name \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_\_ Input Date \_\_\_\_\_ Initials \_\_\_\_\_

ICEP/IEP  OEP  AEP  SEP (type): \_\_\_\_\_ Not eligible: \_\_\_\_\_

Date coverage should begin: \_\_\_\_/\_\_\_\_/\_\_\_\_ **(employer group use only)**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_