To Enroll in ArchCare Advantage, Please Provide the Following Information

Please check which plan you want to enroll in:

□ I-SNP $_____ per month □ IE-SNP $_____ per month

LAST Name:	First Name:	Middle Initial:	□ Mr. □ Mrs. □ Ms.
Birth Date: (____/____/_____) (MM / DD / YYYY)	Sex: □ M □ F	Home Phone Number: ( )	Optional Field: Alternate Phone Number: ( )

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

City:	**County:**	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
- 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.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:_____

Medicare Claim Number Sex _____

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

Is Entitled to Effective Date: _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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 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 ArchCare Advantage 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 cost including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to coverage gap or a late enrollment penalty. Many people are eligible for these savings and do not 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 does not cover.
If you don't select a payment option, you will get a bill each month.
Please select a premium payment option: *If you don't select a payment option, you will get a bill each month.*
□ *Receive 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 approved the deduction. In most cases, if the 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 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 ArchCare Advantage? □ Yes □No

If "yes," please provide the following information:
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.Please choose the name of a Primary Care Physician (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:

☐ Spanish ☐ Braille

Please contact ArchCare Advantage at 1-800-373-3177 if you need information in another format or language than what is listed above. Our office hours are Sunday to Saturday, 8 a.m. to 8 p.m. TTY users should call 1-877-486-2048.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining ArchCare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join ArchCare Advantage. 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 is not 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:

ArchCare Advantage 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 only be in 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. 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.

ArchCare Advantage serves a specific service area. If I move out of the area that ArchCare Advantage 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 ArchCare Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from ArchCare Advantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that people with Medicare are not usually covered under Medicare while out of country except for limited coverage near the U.S. border.

I understand that beginning on the date ArchCare Advantage coverage begins, I must get all of my health care from ArchCare Advantage, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by ArchCare Advantage and other Services contained in my ArchCare Advantage Evidence of Coverage document (also know as member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR ARCHCARE ADVANTAGE 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 ArchCare Advantage, he/she may be paid based on my enrollment in ArchCare Advantage.

Release of information: By joining this Medicare health plan, I acknowledge that ArchCare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that ArchCare Advantage will release my information including my prescription event drug data to Medicare, who may release it for research purposes which follow all applicable Federal statues 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.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and 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 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.

□ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (Insert date) _____ .

□ 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) _____.

□ I am currently employed

□ Spouse currently employed

□ I have supplemental prescription drug coverage under your policy or another family member

□ Receiving Black Lung Benefits

□ I am receiving Workers' Compensation benefits

□ I am receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance.

If none of these statements applies to you or you're not sure, please contact ArchCare Advantage at 1-800-373-3177 (TTY users should call (800)-662-1220) to see if you are eligible to enroll. We are open Saturday to Sunday 8 a.m. to 8 p.m.

□ None of these statements applies to me.

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 (if assisted in enrollment):_____

Plan ID#:_____ Effective Date of Coverage:_____

ICEP/IEP:_____ OEP: _____ AEP: _____ SEP (type): _____

APPLICATION NOTES: