

To Enroll in HAP Senior Plus, Please Provide the Following Information:

Please check the plan you want to enroll in:

- \$20 Premium Option without prescription drugs \$50 Premium Option with basic prescription drugs
 \$70 Premium Option with enhanced prescription drug coverage

* You must live in one of the following counties: Wayne, Oakland or Macomb.

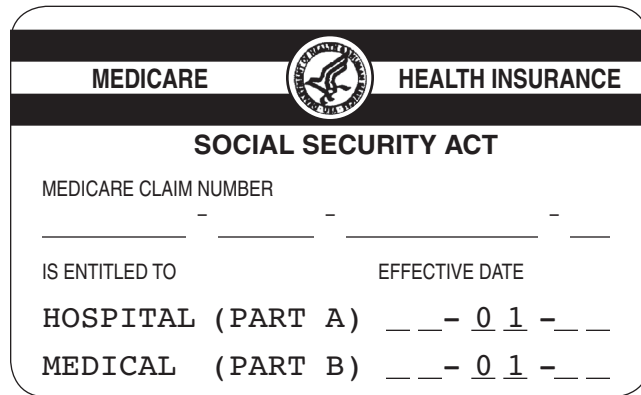
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|--|---|--|----------------------------|------------------------------------|---|
| LAST Name: _____ | | FIRST Name: _____ | | Middle Initial: _____ | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. |
| Birth Date: (__/__/____) <small>M M/D D/Y Y Y Y</small> | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number (providing this information is optional) | | Home Phone Number: (____) _____ | |
| Permanent Residence Address: _____ City: _____ State: _____ ZIP Code: _____ | | | | | |
| Mailing Address (if different from permanent address) Street Address: _____ City: _____ State: _____ ZIP Code: _____ | | | | | |
| Emergency Contact: _____ | | | Relationship to you: _____ | | |
| Phone Number: _____ | | | E-mail Address: _____ | | |

Please Provide the Following 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 Administration or Railroad Retirement Board.

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



Your Plan Premium Option

You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check? Yes No

Please Read and Answer These Important Questions:

- Do you have End Stage Renal Disease (ESRD)? Yes No
 If you answered yes to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.
- 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 HAP Senior Plus? 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: _____
- 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) _____
- Are you enrolled in your State Medicaid program? Yes No
 If yes, please provide your Medicaid number: _____
- Do you or your spouse work? Yes No
Please choose the name of a Personal Care Physician (PCP), clinic or health center:
Medical Center (Name) _____
Personal Care Physician (Name) _____
Personal Care Physician (Code) _____



Please Read This Important Information

If you currently have health coverage from an employer or union, joining HAP Senior Plus could affect your employer or union health benefits. If you have health coverage from an employer or union, joining HAP Senior Plus may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their web site, or contact the office listed in their communications. If there is no 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:

HAP Senior Plus is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to HAP Senior Plus or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

HAP Senior Plus serves a specific service area. If I move out of the area that HAP Senior Plus 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 HAP Senior Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from HAP Senior Plus when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date HAP Senior Plus coverage begins, I must get all of my health care from HAP Senior Plus, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by HAP Senior Plus and other services contained in my HAP Senior Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HAP SENIOR PLUS WILL PAY FOR THE SERVICES.**

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. 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 behalf of the individual under the laws of the State where the individual resides) 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 HAP Senior Plus or by Medicare.

| | |
|------------------------------|----------------------------|
| Your Signature: _____ | Today's Date: _____ |
|------------------------------|----------------------------|

If you are the authorized representative, you must 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): _____