

**Medicare Advantage HMO
Individual Enrollment Request Form**

Health Alliance Plan
2850 W. Grand Blvd., Detroit, MI 48202
Telephone (800) 868-3153
TTY (800) 956-4325

To enroll in HAP Senior Plus (HMO), please check the premium option and which plan you want to enroll in:	HAP Senior Plus Henry Ford	HAP Senior Plus Expanded Network
Option 1 without prescription drugs	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$95.00
Option 2 with prescription drugs	<input type="checkbox"/> \$67.00	<input type="checkbox"/> \$117.00
Option 3 with prescription drugs	<input type="checkbox"/> \$92.00	<input type="checkbox"/> \$139.00
<p>If you also want to enroll in a Dental Plan, please check the plan you want to enroll in:</p> <p><input type="checkbox"/> \$23.40 additional monthly premium Plan 1</p> <p><input type="checkbox"/> \$44.90 additional monthly premium Plan 2</p>	<p>You must live in one of the following counties: Wayne, Oakland or Macomb.</p>	<p>You must live in one of the following counties: Wayne, Oakland, Macomb, St. Clair, Washtenaw, Livingston, Monroe, Lapeer, or Genesee.</p>

LAST Name: _____ FIRST Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Birth Date: (___/___/___) _____ Sex: M F Home Phone Number: (___) _____

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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: _____

Emergency Contact: _____ **Relationship to You:** _____


Phone Number: _____ **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
- OR -
- 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

You can pay your monthly plan premium by mail or “Electronic Funds Transfer (EFT)” each month or quarterly. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 Saving

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please Read and Answer These Important Questions:

1. 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 if you 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.

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 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 _____

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 Personal Care Physician (PCP), clinic or health center:

Medical Center (Name) _____

Personal Care Physician (Name) _____

Personal Care Physician (Code) _____

Please check one of the boxes below if you would prefer us to send you information in another format:

Large print

Audio tape

Please contact HAP Senior Plus toll-free at (800) 868-3153, if you need information in another format from what is listed above. Our office hours are Monday through Friday 8:30 a.m. to 5 p.m. TTY users should call (800) 956-4325.

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. You could lose your employer or union health coverage if you join HAP Senior Plus. 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 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:

HAP Senior Plus 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: November 15 – December 31 of every year), or under certain special circumstances.

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 document from HAP Senior Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Original Medicare only 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 HAP Senior Plus coverage begins, I must get all of my health care from HAP Senior Plus, except for emergency or urgently needed services or out-of-area dialysis services. 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.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HAP Senior Plus, he/she may be paid based on my enrollment in HAP Senior Plus.

Release of Information: By joining this Medicare health plan, I acknowledge that HAP Senior Plus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HAP Senior Plus 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 HAP Senior Plus or by Medicare.

Please keep the yellow copy for your records and return the white copy to HAP Senior Plus.

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): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____