Medicare Advantage Health Plans

Individual Enrollment Application

2020 Rochester/Buffalo Region

Please complete Steps 1–8 on the following pages. Complete one enrollment form per applicant.

Step 1: Please check the plan in which you want to enroll

- ☐ **MVP GoldSecure HMO-POS** **with** prescription coverage, $25.00 monthly premium
- ☐ **MVP® WellSelect® PPO** **with** prescription coverage, $79.00 monthly premium
- ☐ **MVP Preferred Gold HMO-POS** **without** prescription coverage, $115.00 monthly premium
- ☐ **MVP Preferred Gold HMO-POS** **with** prescription coverage, $210.00 monthly premium

Step 2: Please provide the following information (Please print)

☐ **Male** ☐ **Female**

Name (last, first, middle initial) **Gender**

Permanent Residence (Home Address—PO Box is not allowed)

City **State** **Zip Code** **County**

Home Phone Number **Date of Birth**

Mailing Address (if different from permanent address above)

City **State** **Zip Code**

Email **MVP Member ID Number** (if you are a current MVP Medicare Member)

Step 3: Please provide your Medicare Insurance Information (Please print)

Using your Medicare card, 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.

Name (as it appears on your Medicare card) **Medicare Number**

Is Entitled To:

Hospital (Part A) Effective Date **Medical (Part B) Effective Date**

Step 4: Please choose how to pay your plan premium

Select Payment method for your monthly premium and/or any late enrollment penalty you may owe.

☐ **Please bill me.** (Once enrolled, you can register for an account at **mvphealthcare.com** to pay your bill online.)

☐ **Automatically deduct from my monthly Social Security or Railroad Retirement Board benefit check.** (The first deduction may take several months to begin. Continue to pay your bill until the deduction starts.)

I get monthly benefits from: ☐ **Social Security** ☐ **RRB**

If you do not select a payment option, MVP will bill you monthly.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA) by Medicare, 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 Railroad Retirement Board. **Do not** pay MVP 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, visit **ssa.gov/prescriptionhelp**.

Note: 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.

Step 5: Please read and answer these important questions (Please print)

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 EPIC (NY) or V-Pharm (VT). Will you have other prescription drug coverage in addition to MVP? ☐ **Yes** ☐ **No**
   If yes, refer to the ID card for your other drug coverage and provide the following information:

   Name of other coverage: **Effective Date:**

   Rx ID #: **Rx Group #:** **Rx BIN #:** **Rx PCN:**
3. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** *(provide information below)* ☐ **No**
   Name of institution:

   Address and phone number (number and street):

Your answers to the following questions will not keep you from enrolling in this plan.

4. Are you enrolled in your State Medicaid program? ☐ **Yes** (Your Medicaid No: _____) ☐ **No**
5. Do you or your spouse work? ☐ **Yes** ☐ **No**
6. Have you served in the military? ☐ **Yes** ☐ **No**

Step 6: Provide your Primary Care Physician (PCP)—not required for Gold PPO or WellSelect plan members

_____ Are you an existing patient? ☐ **Yes** ☐ **No**

PCP Full Name

Step 7: Please select your reason for enrolling at this time

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15–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 Medicare later determines that this information is incorrect, you may be disenrolled.

- ☐ This is my selection for Annual Enrollment.
- ☐ I am new to Medicare or I had Medicare before, but I am now turning 65.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I am leaving employer or union coverage on (date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I belong to a pharmacy assistance program provided by my state: EPIC (NY) or V-Pharm (VT).
- ☐ 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 (date) _____.
- ☐ I recently had a change in my Medicaid (started receiving Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (date) _____
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (started receiving Extra Help or lost Extra Help) on (date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my coverage on (date) _____.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (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 (date) _____.
- ☐ I recently was released from incarceration. I was released on (date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (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) on (date) _____.
- ☐ I recently left a PACE program on (date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date) _____.
- ☐ I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ☐ None of these statements applies to me. Please call us to see if you are eligible to enroll: **1-800-324-3899** Monday–Friday, 8 am–8 pm. October 1–March 31, call 7 days a week, 8 am–8 pm. (TTY: **1-800-662-1220**)

Step 8: Provide your signature and authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent to the release, use, and disclosure of my information (which may include prescription information, medical information, HIV, mental health, and /or alcohol and substance abuse information) by MVP or any health care provider involved in caring for me to Medicare,MVP, or any health care providers, or organizations involved in my care, and other plans as is reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. I also acknowledge that MVP may release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. 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.

Please Sign Below

Signature **Today's Date**

If you are the authorized representative, you must sign above and provide the following information about yourself:

Name **Relationship to Enrollee**

Address **Phone Number**

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): Plan ID #: Effective date of coverage:

ICEP/IEP: AEP: SEP (type): Not eligible: Agent License #:

By completing this Enrollment Application, I agree to the following:

MVP Health Plan, Inc. 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 Advantage 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.

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. MVP's Medicare Advantage plans offer worldwide coverage for emergency care.

I understand that beginning on the date my HMO-POS or PPO plan 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, MVP provides reimbursements for covered benefits, even if I get services out of network. 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 these 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.

Stop! Please Read This Important Information

If you currently have health coverage from an employer or union, joining an MVP Medicare Advantage plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MVP. 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.

If you would prefer information in a language other than English or in an accessible format (Braille, audio recording, or large print), please call the MVP Medicare Customer Care Center at **1-800-665-7924**, Monday–Friday, 8 am–8 pm. October 1–March 31, call seven days a week 8 am–8 pm. TTY: **1-800-662-1220**.

MVP Health Care Medicare Sales, 220 Alexander St., Rochester, NY 14607

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