

# Priority Health Medicare Employer Group Enrollment Request Form



## Attestation of Eligibility for an Enrollment Period

Please contact Priority Health Medicare if you need information in another language or format (Braille). Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through 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 for the statement that 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.

### Choose one of the following:

- 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). 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 United States 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 am enrolling during my "open enrollment" or "new group benefits."
- I am electing to enroll during the annual enrollment period (Oct. 15 thru Dec. 7).

**Office use only**

Effective date of coverage _____	Group number _____
ICEP / IEP / AEP / SEP (type) _____	Subscriber ID _____
PBP ID _____	
Processing rep _____ Date processed ____/____/____	

**For employer use only**

Group name	Effective date ____/____/____	Employee ID (required)
Group signature		Date ____/____/____

Please select the appropriate plan for this contract

<b>PriorityMedicare<sup>SM</sup></b> (Employer HMOPOS) <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Custom	<b>PriorityMedicare Select<sup>SM</sup></b> (Employer PPO) <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Custom	<b>PriorityMedicare Rx<sup>SM</sup></b> (Employer PDP) <input type="checkbox"/> Custom
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**Section 1 – Enrollment information**

*If enrollee is Medicare eligible, please record name as it appears on his or her Medicare card.*

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Subscriber's last name	First name	M.I.	Social Security number - -
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Street address (permanent address)	E-mail address
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City	County	State	ZIP code
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Mailing address (only if different from your permanent address)

City	County	State	ZIP code
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Home phone	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Retirement date ____/____/____	Birth date ____/____/____
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Subscriber's Priority Health primary care provider (PCP) (not required for **PriorityMedicare Select**)

Have you seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP address / location
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Are you Medicare eligible?  
 Yes  No (If no, please skip to Section 3-Authorization. If yes, please complete questions 1-4 in section 2.)

Spouse / dependent's last name	First name	M.I.	Social Security number - -
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Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date ____/____/____	Spouse / dependent's Priority Health primary care provider (PCP) (not required for <b>PriorityMedicare Select</b> )
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Has this spouse / dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP address / location
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Is this spouse / dependent Medicare eligible?  
 Yes  No (If yes, please complete questions 1-4 in section 2.)

Dependent's last name		First name	M.I.	Social Security number — —
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date ____/____/____	Dependent's Priority Health primary care provider (PCP) (not required for <b>Priority</b> Medicare Select)		
Has this dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP address / location		
Is this dependent Medicare eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete questions 1-4 in section 2.)				

**Premiums**

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 coinsurance. Additionally, those who qualify will not be subject to 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).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your employer premium. If Medicare pays only a portion of this premium, your employer group will bill you for the amount that Medicare doesn't cover.

**If we determine that you owe a late enrollment penalty, your employer will bill you for this amount.**

If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition in any employer premium you may have. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare. DO NOT pay Priority Health or your Employer group the Part D-IRMAA.

**Section 2 – Medicare and other information**

1. Please provide your Medicare information below. This information is contained on your red, white and blue Medicare card. You must have Medicare Part A and Part B to join a Medicare Advantage plan. To join a Medicare prescription drug plan, you must have Medicare Part A or Part B (or both).

Subscriber's Medicare claim number \_\_\_\_\_

Hospital (Part A) effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical (Part B) effective date \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse/dependent's Medicare claim number \_\_\_\_\_

Hospital (Part A) effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical (Part B) effective date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent's Medicare claim number \_\_\_\_\_

Hospital (Part A) effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical (Part B) effective date \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Does any covered member have End-Stage Renal Disease (ESRD)?

Subscriber  Yes  No      Spouse  Yes  No      Dependent  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.

3. Is any enrollee a resident in a long-term care facility, such as a nursing home?  Yes  No

If yes, please provide the following information:

Who? \_\_\_\_\_

Name of institution \_\_\_\_\_

Address and phone number of institution (number and street) \_\_\_\_\_

\_\_\_\_\_

4. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefit coverage, VA benefits, or State pharmaceutical assistance. Does any enrollee have other prescription drug coverage? If so, please complete the information below:

Yes, I have other medical coverage.

Member name \_\_\_\_\_ Name of other coverage \_\_\_\_\_ ID # \_\_\_\_\_

Yes, I have other prescription coverage.

Member name \_\_\_\_\_ Name of other coverage \_\_\_\_\_ ID # \_\_\_\_\_

Please locate these two numbers on the ID card from your other prescription plan and include below.

BIN \_\_\_\_\_ PCN \_\_\_\_\_

If you would prefer us to send you information in another format or language (like Braille or large print), please contact Priority Health Medicare at toll-free 888 389-6648 (TTY users should call 711). Our office hours are 8 a.m. to 8 p.m., 7 days a week.

### Section 3 – Authorization

I apply for coverage for each person listed above & agree that we will abide by the Certificate of Coverage and/or Summary Plan Description and/or Evidence of Coverage that applies to our coverage. I understand that Priority Health cannot process my enrollment form on time unless I fill in all of the information above, in particular, list a PCP (if required) for my enrolled dependents and myself. All of the information I have given above is complete and correct.

Priority Health requires proper handling of personal health information of our members. Details of our confidentiality policies and procedures are available upon request.

Today's date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Subscriber's signature \_\_\_\_\_

### Section 4 – Plan acknowledgement

**If you or any family member listed above is Medicare eligible, please read & sign below:**

Priority Health is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B and I must continue to pay my Medicare Part B premium. 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. It is my responsibility to inform you of any health 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. I may leave this plan ("disenroll") during the Annual Enrollment Period from October 15 - December 7 of every year (effective January 1 of the following year) or under certain limited special circumstances, by sending a written request to Priority Health.

Priority Health Medicare serves a specific service area. If I move out of the area that Priority Health Medicare serves, I need to notify Priority Health Medicare so I can disenroll and find a new plan in my area. Once I am a member of Priority Health Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Priority Health Medicare when I get it to know which rules I must follow in order to get coverage with this 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 Priority Health Medicare coverage begins, I must get all of my services from Priority Health Medicare, except for emergency or urgently needed services or out-of-area dialysis services if I have a Medicare Advantage plan. Services authorized by Priority Health Medicare and other services contained in my Priority Health Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Priority Health Medicare 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 Priority Health Medicare, he/she may be paid based on my enrollment in Priority Health Medicare.

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

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

\_\_\_\_\_  
Subscriber's signature Today's date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Spouse's signature Today's date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Dependent's signature Today's date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If you are the authorized representative, you must provide the following information:

Name \_\_\_\_\_ Relationship to enrollee \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_