

**Enrollment checklist:**

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage.

Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 recently retired. I retired 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 United States after living permanently outside of the U.S.  
I returned to the U.S. on (insert date) \_\_\_/\_\_\_/\_\_\_
- None of these statements applies to me - Please contact Priority Health Medicare at 616 464-8850 or toll-free 888 389-6676 to see if you are eligible to enroll. TTY/TDD users should call 616 464-8485 or toll-free 888 551-6761. We are available 8:30 a.m. – 5:00 p.m. Monday – Friday.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Enrollment instructions**

To avoid delays in processing your enrollment, please follow these helpful tips.

Make sure to complete the entire enrollment form. Please check the appropriate box for the plan you wish to join. Don't forget to sign the form.

Instead of filling in the box at the bottom of page 1, you may simply attach a photocopy of your Medicare card as proof that you have Medicare Parts A and B coverage.

To confirm that the Primary Care Provider (PCP), clinic or health center that you would like to choose is part of the Priority Health Medicare network of providers, please use the PCP list enclosed in this packet, go to *prioritymedicare.com* or call our Priority Health Medicare Specialists at the phone numbers listed below.

There are three options available for paying your plan premium. Please check the appropriate box on the enrollment form of the payment option you would like to use. They are:

- You can receive a bill monthly from Priority Health and you pay the plan directly by mail
- Electronic Fund Transfer (EFT) from your bank account – please attach a voided check or a letter from your financial institution
- Automatic deduction from your monthly Social Security check

## **Enrollment Form checklist:**

Did you:

- Check the appropriate box for the plan you wish to join.
- Choose a Primary Care Provider (PCP) if applicable.
- Complete your Medicare Insurance information or attach a photocopy of your Medicare card as proof that you have Medicare Parts A and B coverage.
- Choose a premium payment option.
- Include a voided check if you chose to pay your premiums by EFT.
- Answer all five questions on page 2 of the form.
- Sign and date the form.

Mail your completed enrollment form in the enclosed postage-paid reply envelope.

Or, if you do not have a postage-paid reply envelope, you can send your completed enrollment form to Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525.

The Provider Directory, Pharmacy Directory and Formulary are available on *prioritymedicare.com*.

After we receive your enrollment form, you will receive a call to verify you understand the rules and benefits associated with the plan you are enrolling in.

If you have any questions regarding enrolling in a Priority Health Medicare plan, please call our Medicare Specialists at 616 464-8850, toll-free 888 389-6676, 24 hours a day, 7 days a week. TTY/TDD users should call 616 464-8485, toll-free 888 551-6761.

# Priority Health Medicare Enrollment Request Form



| Office Use Only                                      | Agent Use Only  |
|--|---|
| Subscriber ID: _____                                 | Referring Agent: _____  |
| Effective Date of Coverage: _____                    | Referring Agent #: _____  |
| ICEP / IEP / OEP / AEP / SEP (type): _____           | Scope of Appointment Included: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| PBP ID: _____  |   |
| Not Eligible: _____                                  |   |
| Processing Rep: _____ Date Processed: ____/____/____ |   |

## To Enroll in Priority Health Medicare, please provide the following information:

Please check which plan you want to enroll in:

**PriorityMedicare Value<sup>SM</sup>** (HMOPOS)  
  **PriorityMedicare<sup>SM</sup>** (HMOPOS)  
  **PriorityMedicare Plus<sup>SM</sup>** (HMOPOS)

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

\_\_\_\_\_

**PriorityMedicare Choice<sup>SM</sup>** (PPO) (A primary care provider is not required for the PPO plan.)

|  |   |                          |       |                               |  |
|--|---|--------------------------|-------|-------------------------------|--|
| Last Name  |   | First Name               |       | M.I.                          | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.<br><input type="checkbox"/> Ms. |
| Birth Date<br>____/____/____<br><small>MM DD YYYY</small>                        | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Home Phone Number<br>( ) |       | Alternate Phone Number<br>( ) |  |
| Permanent Residence Street Address (P.O. Box is not allowed)                     |   |                          |       |                               |  |
| City   |   | County                   | State | ZIP Code                      |  |
| Mailing Street Address (only if different from your Permanent Residence Address) |   |                          |       |                               |  |
| City   |   |                          | State | ZIP Code                      |  |
| Email Address  |   |                          |       |                               |  |

## Please provide your medicare insurance information

|  |   |                |                |                         |       |                        |       |
|--|---|----------------|----------------|-------------------------|-------|------------------------|-------|
| <p>Please refer to your Medicare Card to complete this section.</p> <p>Please fill in these blanks so they match your red, white and blue Medicare card</p> <p>– OR –</p> <p>Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</p> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p> | <p>Name: _____</p> <p>Medicare Claim Number: _____</p> <p>Sex: _____</p><br><table style="width: 100%;"> <tr> <td style="width: 50%;">Is Entitled To</td> <td style="width: 50%;">Effective Date</td> </tr> <tr> <td>HOSPITAL (Part A) _____</td> <td>_____</td> </tr> <tr> <td>MEDICAL (Part B) _____</td> <td>_____</td> </tr> </table> | Is Entitled To | Effective Date | HOSPITAL (Part A) _____ | _____ | MEDICAL (Part B) _____ | _____ |
| Is Entitled To   | Effective Date  |                |                |                         |       |                        |       |
| HOSPITAL (Part A) _____  | _____   |                |                |                         |       |                        |       |
| MEDICAL (Part B) _____   | _____   |                |                |                         |       |                        |       |

## Paying your plan premium

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of 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](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 plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay your late enrollment penalty and/or monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

If you don't select a payment option, you will get a bill each month.

### Please select a premium payment option:

- Get a bill monthly and pay the plan directly by mail.
- Electronic funds transfer (EFT) from your bank account each month.  
You must enclose a VOIDED check, otherwise you will be billed directly for your monthly premium.
- 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 Priority Health Medicare?  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

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/TDD users should call toll-free 888 551-6761), 24 hours a day, 7 days a week.

**Please read this important information**

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

**Please read and sign below:**

**By completing this enrollment application, I agree to the following:**

Priority Health Medicare plans are Medicare Advantage plans and have 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. 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.

Priority Health Medicare serves a specific service area. If I move out of the area that Priority Health Medicare 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 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 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.

I understand that beginning on the date **Priority**Medicare Value (HMOPOS), **Priority**Medicare (HMOPOS), or **Priority**Medicare Plus (HMOPOS) coverage begins, I must get all of my health care from Priority Health Medicare, except for emergency or urgently needed services or out-of-area dialysis services. I understand that beginning on the date **Priority**Medicare Choice (PPO) 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, Priority Health Medicare provides refunds for all covered benefits, even if I get services out of network. 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 as well as 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.

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: \_\_\_\_\_



Life just got a little easier.®