ENROLLMENT FORM INSTRUCTION SHEET

Please follow these instructions to complete your Passport Advantage (HMO SNP) Enrollment Form. If you have any questions about how to complete your Enrollment Form, please contact Passport Advantage by calling 1-800-578-0603 then press 1. TTY users please call 1-800-648-6056. We are available 7 days a week from 8:00 a.m. to 8:00 p.m. This form is available in alternative formats such as Braille, other languages, large type and audio. Please contact Passport Advantage for more information.

Part A – Your Personal Information

Please fill out your personal information.

Part B – Medicare Insurance Information

Complete the information requested in this section using your current Medicare ID card.

Part C – Additional Information About You

Complete the information requested in this section.

Part D – Important – Read the Back of the Enrollment Form and Sign the Form

Please read the information on the back of the Enrollment Form.
Return the signed form in the postage-paid envelope.

Please keep the GOLD copy of the Enrollment Form as a temporary ID.

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ENROLLMENT REQUEST FORM

Office Use Only:
Name of staff member/agent/broker
(if assisted in enrollment): ______
Plan ID # H1807 Verified: ______
Effective Date of Coverage: ______ County: ______
❑ ICEP/IEP ❑ AEP ❑ SEP (type) ❑ Not Eligible <NIPR#>

Please contact Passport Advantage HMO SNP if you need information in another language or format (Braille).

A. YOUR PERSONAL INFORMATION

LAST Name: **FIRST** Name: **MIDDLE** Initial: ❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) | Sex: ❑ M ❑ F | Home Phone Number: ( ) | Alternate Phone Number: ( )

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: ______

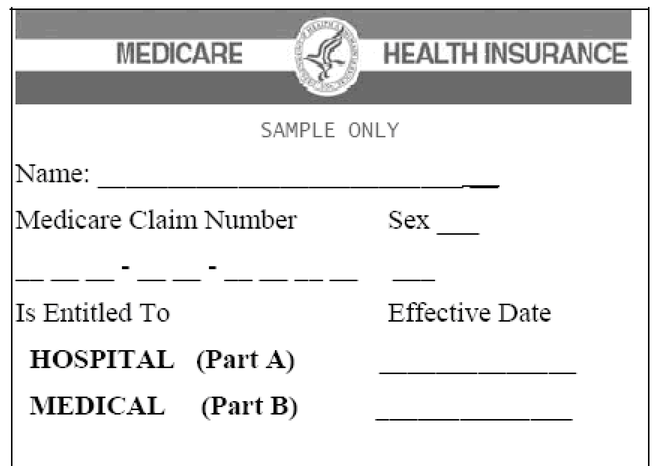
Emergency contact: ______
Phone Number: ______ Relationship to You: ______

E-mail Address (optional):

B. 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, including Passport Advantage HMO SNP.



Paying Your Plan Premium: (*Note: Passport Advantage members do not have a monthly plan premium.*)
If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

C. ADDITIONAL INFORMATION ABOUT YOU

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 Passport Advantage? ❑ 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 (Passport Health Plan)? ❑ Yes ❑ No
If yes, please provide your Passport Health Plan (Medicaid) number:

5. Do you or your spouse work? ❑ Yes ❑ No

Please list the name of a Primary Care Physician (PCP), if you have one: | PCP ID Number:

PCP Address: | PCP Phone Number:

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D. IMPORTANT – READ BACK OF ENROLLMENT FORM AND SIGN BELOW

Signature: | Today's Date:

If you are the authorized representative, power of attorney, or legal guardian, you must sign above and provide the following information:
Name: ______
Address: ______
Phone Number: ( ) ______ - ______ Relationship to Enrollee: ______

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Passport Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Passport Advantage. 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 BEFORE SIGNING

By completing this enrollment application, I agree to the following:
Passport Advantage 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.

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. Passport Advantage members do not need to re-enroll every year, and are eligible to end their membership during any month of the year. This is known as a Special Election Period.

Passport Advantage serves a specific service area. If I move out of the area that Passport Advantage 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 Passport Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Passport Advantage 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.

I understand that beginning on the date Passport Advantage coverage begins, I must get all of my health care from Passport Advantage, except for emergency or urgently needed services or out-of-area dialysis services. I must call Passport Advantage for authorization to see out-of-network providers.

Services authorized by Passport Advantage and other services contained in my Passport Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PASSPORT ADVANTAGE 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 Passport Advantage, he/she may be paid based on my enrollment in Passport Advantage.

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

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