PacificSource Medicare

2018 Medicare Advantage Enrollment Form

Portland Metro – Oregon and Washington

To enroll in a PacificSource Medicare plan, provide the following information

First Name _____ Last Name _____ MI _____

Birth Date ____/____/____ Sex ☐ M ☐ F Requested Effective Date _____

Phone (_____)_____ Email _____

Permanent Residence (PO Box not allowed) Street _____

City _____ State _____ ZIP _____ County _____

Mailing Address (only if different from permanent residence) Street _____

City _____ State _____ ZIP _____ County _____

Primary Care Provider: First Name _____ Last Name _____

Are you an established patient? ☐ No ☐ Yes Are you a current PacificSource Medicare member? ☐ No ☐ Yes

Check the plan you want to enroll in for 2018

☐ **$76/mo** MyCare™ Rx 28 (HMO) - Oregon
☐ **$23/mo** MyCare™ Rx 31 (HMO) - Oregon
☐ **$37/mo** MyCare™ Rx 28 (HMO) - Washington
☐ **$7/mo** MyCare™ Rx 31 (HMO) - Washington

☐ Optional Supplemental Dental **$28/mo** in addition to your monthly plan premium above

Please take out your red, white and blue Medicare card to complete this section.

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.
-OR- Fill out the information below **as it appears on your Medicare card**.

Name _____ Medicare Number _____

Is Entitled To ☐ HOSPITAL (Part A): Effective Date _____
☐ MEDICAL (Part B): Effective Date _____

You must have **Medicare Part A and Part B** to join a Medicare Advantage plan.

Paying your plan premium

You can pay your monthly plan premium (optional dental benefits, and any late enrollment penalty you have or may owe) with one of the options below. *Note: If you don't select an option, we'll keep your current option or send you a bill.*

☐ **Get a monthly bill.**
☐ **Automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check.***
I get monthly benefits from ☐ Social Security ☐ RRB
☐ **Automatic deduction from your checking account each month. Please include a voided check or provide the following:**

Account Holder Name _____ Bank Routing Number _____

Bank Account Number _____ Account Type: ☐ Checking ☐ Savings

Automatic deductions are made on the 5th day of every month. Deductions include any outstanding balance on your account. If the deduction falls on a weekend or holiday, the deduction will occur the next business day. Please provide a voided check (deposit slips not accepted). You can stop deductions from your account by notifying us at the phone number or address on page 4 at least 30 days prior to the deduction date.

☐ **Credit card.** Once you're enrolled, we'll send you information about setting up credit card payments.

For agent use only:

Agent Name* _____

Agent ID* PM _____ **Date Received by Agent*** _____

ICEP/IEP _____ AEP _____ SEP (type) _____ Not eligible _____ ***Required**

*(The Social Security/RRB deduction may take two or three months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions

1. **Do you have End-Stage Renal Disease (ESRD)?** ☐ No ☐ Yes
   If "yes," and you've had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to get additional information.
2. **Are you enrolled in your State Medicaid program?** ☐ No ☐ Yes Medicaid Number _____
3. **Will you have, or have you had, other medical and/or prescription drug coverage in addition to your Medicare coverage and PacificSource Medicare?** (For example, other private insurance, TRICARE, Federal employee health benefits, or VA benefits, or State pharmaceutical assistance programs.) ☐ No ☐ Yes
   If "yes," please include: Effective Date _____ Termination Date _____
   Subscriber Name _____ Insurance Company _____
   Group Name _____ ID Number _____ Group Number _____
4. **Are you a resident in a long-term care facility, such as a nursing home?** ☐ No ☐ Yes **If "yes," provide:**
   Name of Institution _____ Phone Number of Institution (_____)_____
   Institution Address (number and street) _____
5. **Do you or your spouse work?** ☐ No ☐ Yes

Please confirm your eligibility for an enrollment period

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. If none of these statements apply to you or you're not sure, please contact Customer Service using the information in the Contact Information section on the back page.

Please read the following carefully and check the box if the statement applies to you. By checking any of the following boxes you certify that, to the best of your knowledge, you're eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled. **Check all that apply**.

☐ I'm enrolling during the annual enrollment period (October 15 – December 7).
☐ I'm new to Medicare.
☐ I recently moved outside the service area of my current plan, or recently moved and this plan is a new option for me. I moved on _____ (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 effective _____ (date).
☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on _____ (date).
☐ I'm moving in, live in, or recently moved out of a Long Term Care Facility (i.e., nursing home). I moved or will move in on _____ (date) or moved/will move out on _____ (date).
☐ I recently left a PACE program on _____ (date).
☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) on _____ (date).

☐ I'm leaving employer or union coverage on _____ (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 United States. I returned to the United States on _____ (date).
☐ I recently obtained lawful presence status in the United States. I got this status on _____ (date).
☐ I recently was released from incarceration. I was released 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 have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ (date).
☐ None of the above statements apply to me. I feel I have a special circumstance which allows me an exception to enroll. Please include the reason: _____

Please read all sections of this document before signing

Signature _____ Today's Date _____

Relationship to beneficiary: ☐ Self ☐ Authorized Representative ☐ Other

If you are the authorized representative and you signed this form, complete the following:

Name _____ Address _____
Phone _____ Relationship to Enrollee _____

You understand your signature (or the signature of the person authorized to act on your behalf under the laws of the State where you live) on this application means you 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.

Important information about paying your plan premium

If you are assessed a Part D Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your monthly premium. You will either have the amount withheld from your monthly Social Security check or be billed directly by Medicare or the Railroad Retirement Board (RRB). **DO NOT** pay PacificSource Medicare 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 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 Social Security at (800) 772-1213. TTY users should call (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.

Materials in Alternate Formats

Please check one of the boxes below if you would prefer us to send you information in another format:
☐ Braille ☐ Audio tape ☐ Large print

Please contact Customer Service toll-free at (888) 863-3637, or TTY users call (800) 735-2900, if you need information in another format than what is listed above. Our hours are listed on the last page of the application.

Employer or union information

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

By completing this application, you agree to the following

PacificSource Medicare 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.

PacificSource Medicare serves a specific service area. If I move out of the area that PacificSource 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 PacificSource Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (also known as a member contract or subscriber agreement) from PacificSource Medicare 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 PacificSource Medicare coverage begins, I must get all of my health care from PacificSource Medicare, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by PacificSource Medicare and other services contained in my PacificSource Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR PacificSource Medicare WILL PAY FOR THE SERVICES.

Release of your information

By joining this Medicare health plan, you acknowledge PacificSource Medicare (we) will release your information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. You also acknowledge we will release your information including your prescription drug event data if you have a Medicare Advantage Part D plan 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 your knowledge. You understand if you intentionally provide false information on this form, you will be disenrolled from the plan.

Submit your completed enrollment form

Send completed enrollment form to us at:
Fax: (541) 382-4217 or (855) 382-4217 toll-free
Email: medicareapplications@pacificsource.com
Mail: PacificSource Medicare | PO Box 7469 | Bend, OR 97708
Enroll Online: www.Medicare.PacificSource.com

Questions?

If you have questions, please call our Customer Service Department toll-free at (888) 863-3637 or (800) 735-2900 TTY. We're always happy to help you.
October 1 - February 14: 8:00 a.m. - 8:00 p.m., seven days a week
February 15 - September 30: 8:00 a.m. - 8:00 p.m., Monday - Friday

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. You will need to keep your Medicare Parts A and B. You must continue to pay your Medicare Part B premium.