

# Today's Options® PFFS

## Medicare Advantage Health Plans

## 2010 Change Notice Form

Current Today's Options PFFS members can use this change form to change their enrollment election to a different Today's Options PFFS plan, change their premium payment option or to update contact information.


### Section 1: Plan and Premium Payment Options

I am currently a member of the \_\_\_\_\_ plan in American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company with a monthly premium of \$ \_\_\_\_\_ . \_\_\_\_\_ .

**Please check which plan you would like to change to:**

- Value (PFFS) \$ \_\_\_\_\_ . \_\_\_\_\_ per month
- Value powered by CCRx (PFFS) \$ \_\_\_\_\_ . \_\_\_\_\_ per month
- Premier (PFFS) \$ \_\_\_\_\_ . \_\_\_\_\_ per month
- Premier powered by CCRx (PFFS) \$ \_\_\_\_\_ . \_\_\_\_\_ per month

### Section 2: Personal Information

	
Last Name	Suffix
First Name	MI
Medicare Claim Number	
Is Entitled to Hospital Insurance (Part A)	Effective Date
Medical Insurance (Part B)	

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.
- Remember you must have Medicare Part A and Part B to join a Medicare Advantage plan, such as Today's Options PFFS.

**An incorrect or incomplete Medicare claim number may cause a delay or denial of coverage.**

Member ID:	Primary Phone Number:
_____	(____) _____ - _____

**Permanent Residence Street Address Line 1: (May not be a P.O. Box)**

Street Number \_\_\_\_\_ Street Name \_\_\_\_\_

Permanent Residence Street Address Line 2: (Apt/Suite/Unit)	County:
_____	_____

City:	State:	ZIP Code:
_____	_____	_____

**Mailing Address:**  Same as permanent address

**Mailing Street Address Line 1:**

Street Number \_\_\_\_\_ Street Name or P.O. Box Number \_\_\_\_\_

Mailing Street Address Line 2: (Apt/Suite/Unit)	County:
_____	_____

City:	State:	ZIP Code:
_____	_____	_____



#### Section 4: Acknowledgement of Enrollment – Read and Sign Below *(continued)*

If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our Web site at [www.todaysoptions.com](http://www.todaysoptions.com).

Once Today's Options PFFS has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in Today's Options PFFS. If Today's Options PFFS is not able to reach you by telephone, then you will get a letter by mail that contains similar information.

Today's Options PFFS is a Medicare Advantage Private Fee-for-Service plan and has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Today's Options PFFS, he/she may be paid based on my enrollment in Today's Options PFFS.

**Release of Information:** By joining this Medicare health plan, I acknowledge that Today's Options PFFS will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Today's Options PFFS 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 people with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Please indicate your enrollment period:  AEP (11/15/2009 – 12/31/2009)  
 OEP (1/1/2010 – 3/31/2010)

If SEP, please choose one of the reasons below:

- I am new to Medicare, but not 65.
- I am turning 65, but am not new to Medicare.
- I recently moved outside of the service area for my current plan. I moved on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I recently moved and this plan is a new option for me. I moved on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- 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 \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home, a Special Needs Care facility or other institution). I moved/will move into/out of the facility on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I recently left a PACE program on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I no longer qualify for Special Needs assistance.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I am leaving employer or union coverage on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- My current plan is ending its Medicare contract.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Section 4: Acknowledgement of Enrollment – Read and Sign Below** *(continued)*

I am eligible for coverage through the Department of Veteran Affairs.

Other \_\_\_\_\_.

If your enrollment period is not listed or you have questions regarding your enrollment eligibility, please contact Today's Options PFFS at 1-800-996-8867, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-777-9083) everyday.

**Your Signature:**

**Your Name:** (please print)

**Today's Date:**

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use): (Power of Attorney (POA) documentation needs to be submitted with the application)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Relationship to Enrollee:  Child  Friend  Spouse  Other\_\_

**Section 5: Agent and Today's Options PFFS Use Only**

**Agent Name** (please print): \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Agent ID #:** \_\_\_\_\_

**Agent Signature:**

**Plan Name:** \_\_\_\_\_

**Effective Date of Coverage:** \_\_\_\_\_

Today's Options® PFFS is a Medicare-approved Medicare Advantage plan offered by the following organizations that contract with the Federal government: American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company, members of the Universal American family of companies.

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at [www.todaysoptions.com](http://www.todaysoptions.com).