UPMC *for Life*

UPMC Health Plan Medicare Program

2012 INDIVIDUAL HMO/PPO APPLICATION
Pennsylvania

OFFICE USE ONLY			
Plan ID#:		Effective Date:	
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:
Plan Representative/Broker:			
If you assisted with application, sign and date here:			
Application Mailed: ________________		Faxed: ________________	

If you have questions about this form, please call us at 1-877-381-3765. TTY/TDD users should call 1-800-361-2629.

Please contact UPMC for Life if you need information in another language or format (e.g., Braille).

I. TO ENROLL, IN UPMC *for Life*, PLEASE PROVIDE THE FOLLOWING INFORMATION

Name: First M.I. Last		Home phone number: ( )
Date of birth: mm/dd/yyyy	Sex: ☐ Male ☐ Female	Alternate phone number (optional): ( )
E-mail address (optional):	Do we have your permission to send you information (e.g., newsletters, health information) via e-mail? ☐ Yes ☐ No	
Permanent residence address (Street, Apartment #): *P.O. Box is not allowed.*		
City: State: Zip code:		County:
Mailing address (Street, Apartment #): *Only complete if different from permanent residence address.*		
City: State: Zip code:		County:

2. PROVIDE YOUR MEDICARE INFORMATION

Please fill in the card to the right with the information from your red, white, and blue Medicare card. Otherwise, please attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Parts A and B to join our Plan. **We cannot consider your enrollment complete until you have given us this information.**

MEDICARE HEALTH INSURANCE

Sample Only

Name of beneficiary: ____________________

Medicare claim number: ____________________

Is entitled to: Effective date:

☐ Hospital Insurance (Part A) ____________

☐ Medical Insurance (Part B) ____________

3. PLEASE CHECK WHICH UPMC *for Life* PLAN YOU WANT TO ENROLL IN

You must continue to pay your Medicare Part B premium, in addition to the UPMC *for Life* premium, if applicable.

☐ UPMC *for Life* (HMO) - $0 monthly premium – ***This HMO plan does not include prescription drug coverage.***

☐ UPMC *for Life* HMO Rx (HMO) - $69.50 monthly premium

☐ UPMC *for Life* HMO Rx Enhanced (HMO) - $196.50 monthly premium

☐ UPMC *for Life* PPO Rx (PPO) - $81.50 monthly premium

☐ UPMC *for Life* PPO High Deductible with Rx (PPO) - $0 monthly premium*

4. SELECT A PRIMARY CARE PHYSICIAN (PCP) – HMO PLANS ONLY

Name of selected PCP: ____________________ PCP # (from enclosed provider directory): ____________________

Are you currently a patient of this physician? ☐ Yes ☐ No

5. SELECT A UPMC *for Life* PREMIUM PAYMENT OPTION

You can pay your monthly plan premium (including any late enrollment penalty that you may owe), by check, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

I would like to pay my monthly plan premium, if applicable, by:
☐ Paper Check ☐ EFT ☐ Credit Card

If you elected to pay your premium by credit card or EFT, please complete the enclosed Payment Election Form and return it with your application.

☐ **Automatic deduction from my monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

The Social Security/RRB deduction may take two or more 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.

***Late Enrollment Penalty:** If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will include this amount on your monthly premium bill. If you are enrolled in a zero dollar premium plan and have a late enrollment penalty, we will send you a premium bill each month which you can pay by check, Electronic Funds Transfer (EFT), or credit card. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security or RRB benefit check each month.

Part D IRMAA: 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 plan premium and/or late enrollment penalty. You can either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay UPMC *for Life* the Part D-IRMAA.**

Low Income Subsidy: 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 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.

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 only pays a portion of your plan premium, we will bill you for the amount that Medicare doesn't cover.

6. OTHER HEALTH INSURANCE INFORMATION

1) Do you or your spouse work full time? ☐ Yes ☐ No
Are you receiving group health insurance through your or your spouse's employer? ☐ Yes ☐ No

2) Will you have other medical coverage in addition to UPMC *for Life*? ☐ Yes ☐ No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name:	ID number:
Insurance company phone #:	Group number:
Subscriber name:	Subscriber date of birth:

3) Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
If "yes," please provide your Medicaid number: ____________________

White copy: UPMC *for Life* **Duplicate copy:** MEMBER

6. OTHER HEALTH INSURANCE INFORMATION (CONTINUED)

Some individuals may have other **drug coverage**, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs (e.g., PACE).

4) Will you have other prescription drug coverage in addition to UPMC *for Life*? ☐ Yes ☐ No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name:	
ID number:	Group number:

7. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

(a) Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
You may be able to enroll in this plan, if you are currently enrolled in a UPMC Health Plan commercial product or if you have had a successful kidney transplant, and/or you no longer need regular dialysis, please attach a note or records from your doctor. If this documentation is not attached, we may need to contact you to obtain additional information.

(b) Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes" please provide the following information *(this will NOT prevent you from enrolling in our plan):*

Name of Institution: ______________________ Phone Number of Institution: ________________

Address of Institution: ______________________________________

8. INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan 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 all of the boxes to the left of the statements that apply to you.** By checking any of the 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 left a Program for All Inclusive Care for the Elderly program on (insert date) ____________.
☐ I am either losing or leaving my employer or union group coverage on (insert date)________.	☐ I get extra help paying for Medicare prescription drug coverage.
☐ 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 belong to a pharmacy assistance program provided by my state (e.g., PACE).
☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ______________.	☐ I recently left a pharmacy assistance program (e.g., PACE) on (insert date) ____________.
☐ I am moving into, live in, or recently moved out of a long-term care facility (e.g., nursing home). I moved/will move into/out of the facility 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)____________.
☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. ☐ None of these statements apply to me.	☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the required special needs qualification. I was disenrolled from the SNP on (insert date) ________.

9. ALTERNATIVE FORMAT OPTIONS

If you require information in an alternative format, please check one of the boxes below or contact UPMC *for Life* at the phone number provided on page 1 of this application.

☐ Audio ☐ Large Print ☐ Braille ☐ Language (please list) ____________________________

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that UPMC *for Life* will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UPMC *for Life* will release my information, including my prescription drug event data (if applicable), to Medicare, which may release it for research and other purposes that 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 from Medicare. **Your signature on this application means that you have reviewed and understand the plan benefits/premium and Rights and Responsibilities listed at the BEGINNING of this form.**

I completed this application with assistance from a UPMC Health Plan representative.
☐ Face-to-face meeting ☐ Telephone call ☐ Completed by myself

Signature:____ Today's Date:________________________

Verification call number:
Please call me to verify my enrollment at the telephone number I provided on page 3 of the application or the number provided below:
☐ **Home number** ☐ **Alternate number** ☐ **Telephone number listed:** ________________________________

If you are the **authorized representative**, you must sign above and provide the following information:

Name: ____ Relationship to enrollee: _________________

Address: ____ Phone number: (______)_________________

Please return the WHITE COPY to UPMC *for Life* in the **postage-paid envelope** provided. **Please keep the Duplicate Copy for your records.**

White copy: UPMC *for Life* **Duplicate copy:** MEMBER

UPMC *for Life* Rights and Responsibilities

By completing this enrollment application I agree to the following statements:

(a) I understand that if I currently have health coverage from an employer group or union, joining UPMC *for Life* could affect my current employer or union health benefits. I could lose my employer or union health coverage if I join UPMC *for Life*. I will read the communications my employer group or union sends me. If I have questions, I will visit their website or contact the office listed in their communications. If there is no information on whom to contact, I will contact the benefits administrator.

(b) UPMC *for Life* is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B coverage. I understand that I can be a member of only one Medicare Advantage plan at a time and that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. **I understand that when I am enrolled in UPMC *for Life* Medicare Advantage Prescription Drug Plan, I will receive my Medicare prescription drug coverage through this plan. I do not need to enroll in a separate Prescription Drug Plan (PDP).**

(c) I understand it is my responsibility to inform UPMC *for Life* of any prescription drug coverage that I have or may get in the future through another plan. 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.

(d) I understand that 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.

(e) UPMC *for Life* serves a specific service area. I understand that if I move permanently out of the service area that UPMC *for Life* serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

(f) I understand that, once I am member of UPMC *for Life*, I have the right to appeal plan decisions about payments, services, or prescriptions if I disagree. I will read the Evidence of Coverage document from UPMC *for Life* when I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan.

(g) **<u>HMO Plans Only</u>:** I understand that beginning on the date UPMC *for Life* coverage begins, I must get all of my health care from UPMC *for Life*, except for emergency or urgently needed services or out-of-area dialysis services.

(h) **<u>PPO Plans Only</u>:** I understand that beginning on the date UPMC *for Life* 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 services are medically necessary, UPMC *for Life* provides refunds, minus the out-of-network cost-sharing, for all covered benefits, even if I get services out-of-network. For more details, please refer to the Evidence of Coverage.

(i) Services authorized by UPMC *for Life* and other services contained in my UPMC *for Life* Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. If a service requires an authorization and one is not obtained, **NEITHER MEDICARE NOR UPMC *for Life* WILL PAY FOR THE SERVICES.**

(j) I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with UPMC *for Life*, he or she may be paid based on my enrollment in this plan.

(k) I understand that a UPMC *for Life* representative is required to call me within fifteen days of UPMC *for Life* receiving this application to verify my enrollment in the plan. I will indicate which phone number UPMC *for Life* should use at the time I sign and date this application on page 6.

UPMC HEALTH PLAN

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

www.upmchealthplan.com/medicare

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UPMC *for Life*

UPMC Health Plan Medicare Program

UPMC *for Life* Medicare Advantage Plan

2012 Individual HMO/PPO Application

Pennsylvania

For assistance completing this application, call
UPMC *for Life* toll-free **1-877-381-3765**
TTY/TDD users call **1-800-361-2629**

Return the application in the postage-paid envelope or send to the following address:

UPMC *for Life*
P.O. Box 2967
Pittsburgh, PA 15230

Or you can fax the application to
UPMC *for Life* at: **412-454-7766**.

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UPMC *for Life*

UPMC Health Plan Medicare Program

Enrollment Application Instructions:

General Instructions

Please fill out each section of the enclosed application completely. **All information must be completed and the application signed, in order for your enrollment form to be processed.**

> **NOTE:** Medicare beneficiaries may enroll in UPMC *for Life* through the CMS Online Enrollment Center located at www.medicare.gov/MPPF/Include/DataSection/Questions/EnrollDirectly.asp. For more information contact our plan at the phone numbers listed below.

Section 1 – Name and Address Information: Complete your name and address information. The permanent residence address field must be your physical street address. Please do not list a P.O. box address in the permanent address field.

Section 2 – Medicare Information: Provide your name, Medicare Claim number, and effective dates (Parts A and B) exactly as they appear on your red, white, and blue Medicare identification card. You must have Medicare Part A and Part B to join a Medicare Advantage Plan. Your application cannot be finalized until UPMC *for Life* has your Medicare Claim number and effective dates of coverage.

Section 3 – Benefit Plan Option: Select one UPMC *for Life* benefit plan option (HMO or PPO).

Section 4 – Primary Care Physician Selection (HMO Plan Only): If you choose one of our HMO plans, you will need to select a primary care physician (PCP) to coordinate your care. Please indicate the PCP name and 4-digit PCP number, which you can obtain from the UPMC *for Life* provider directory included in this enrollment kit.

Section 5 – Premium Payment Option: Select the method you would like to use to pay your premium, if applicable. If you select Electronic Funds Transfer (EFT) or credit card, you will need to complete the Payment Election Form included in this packet and return it with the application.

Sections 6 and 7 – Other Health Insurance Information and Questions: If you have other health or prescription drug coverage, please provide this information. Also provide answers to the questions in Section 7 regarding end-stage renal disease and long-term care facility residence.

Section 8 – Information to Determine Your Enrollment Period: Read the statements and select the boxes that apply to you. By checking any of the boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period.

Section 9 – Alternative Format Options: If you require information in an alternative format, please select the format that best fits your needs. If you do not see a format you need listed in this section, please contact UPMC *for Life* Member Services. If you do not need an alternative format, you may skip this section.

Sign and Date the Application: After you have read the UPMC *for Life* Rights and Responsibilities statements carefully and completed the enrollment application, please sign and date the application where indicated.

For questions about this application, call UPMC *for Life* at 1-877-381-3765, seven days a week from 8 a.m. to 8 p.m. TTY/TTD users should call 1-800-361-2629. (From February 15 through October 14, we are available from 8 a.m. to 8 p.m., Monday through Friday, and from 8 a.m. to 3 p.m. on Saturday.) Please contact our plan if you need information in another language or format (e.g., Braille).