2012 Individual Enrollment Form

When you are ready to enroll

Contact your local sales agent to help you choose the best plan for you and complete this individual enrollment form, **or**

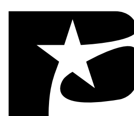
Call a Physicians Health Choice sales agent who can help you enroll over the phone. Toll-free: **1-866-658-2053,** TTY **711,** 7 a.m. – 9 p.m. local time, 7 days a week, 10/15 – 3/1; 7 a.m. – 9 p.m. local time, Monday – Friday, 3/2 – 10/14.

Note: If you do not have an agent helping you enroll, please complete the enrollment form, sign and date it, and send the enrollment copy to: Physicians Health Choice, P.O. Box 690670, San Antonio, TX 78269.

I understand the person who is discussing plan options with me is a sales agent, broker or other person employed by or contracted with Physicians Health Choice. The person may be paid based on my enrollment in a plan.

If you currently have health coverage through an employer or union, joining one of our plans 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 their office. If you can't find any contact information, your benefits administrator or the office that answers questions about your coverage can help.

Turn the page to enroll.



Physicians Health Choice™

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2012 Individual Enrollment Form

Please contact Physicians Health Choice if you need information in another language or format (audio tape).

For sales representative/agency use only

☐ New Member ☐ Plan Change	Employer Group ID Number	Branch ID

Where did this application originate from? ☐ 1. Retail/Mall Program ☐ 2. Community Meeting ☐ 3. Member Meeting ☐ 4. Local B2B Outreach ☐ 5. Local Event Outreach ☐ 6. Other

How was this application submitted? ☐ Appointment ☐ Mail in ☐ Other

1. Applicant information (please type or print in black or blue ink)

Last Name	First Name	Middle Initial
Birth Date ______ / ______ / ______	Gender ☐ Male ☐ Female	☐ Mr. ☐ Mrs. ☐ Ms.

Home Telephone Number ( )	Alternate Phone Number (optional) ( )

Permanent Residence Street Address (not a P.O. Box)

City	State	ZIP Code	County

Mailing Address (only if different from your Permanent Residence Street Address)

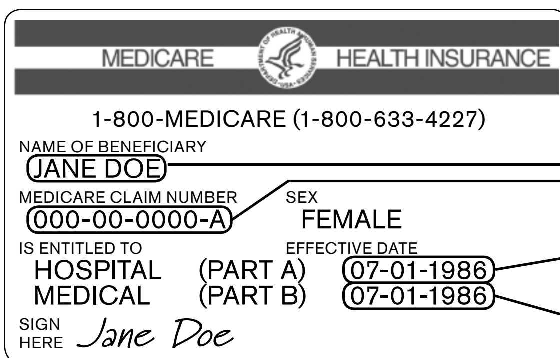
City	State	ZIP Code

Email Address (optional): Please email me plan information and updates.

Emergency Contact (optional)	Phone Number (optional)	Relationship to you (optional)

2. Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section — **or** — Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Name (exactly as appears on Medicare Card)

___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___
Medicare Claim Number Letter(s)

Part A (Hospital) effective date ____ / ____ / ____

Part B (Medical) effective date ____ / ____ / ____

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

Enrollee's name ______________________________

Proposed effective date ____ / ____ / ____

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3. Your payment options (if applicable)

If we determine that you owe a late-enrollment penalty (or if you currently have a late-enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT) each month or we will provide you a monthly statement. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. 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. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Physicians Health Choice 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 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 pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover.

(If you do not select a payment option, you will receive a monthly statement for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.)

Please select a premium payment option (choose only one):

☐ **Automatic deduction from your 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.).*

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.
Enclose a **voided** check or provide the following:
Account Holder Name ____________________________ Bank Routing Number__________________
Bank Account Number ____________________________ Account Type ☐ Checking

Or choose to receive a Monthly Statement
☐ Monthly Statement

4. Benefit plan selections (choose only one)

Health Maintenance Organization (HMO) plans with a medical and Part D drug benefit
☐ Physicians Health Choice Total (HMO)

Enrollee's name ____
Proposed effective date _____ / _____ / _____

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5. Primary Care Physician (PCP), clinic or health center selection

Refer to your Provider Directory or the Plan website to select a PCP Provider ID# ______________________
PCP name ______________________
Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

6. Please read and answer these important questions

Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
If "yes," are you currently a member of a health care company? ☐ Yes ☐ No
If "yes," name of company ______________________ Member ID# ______________

Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage? ☐ Yes ☐ No Plan name of other coverage ______________________
Member ID# for this coverage ______________________
Group ID#______________________ Effective Date (optional) ______________

Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ Yes ☐ No
If "yes," name of institution ______________________
Address of institution ______________________
City, State, ZIP Code ______________________
Phone number of institution (_____) ____________ Date of admission to the institution ____ /____ /____

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
If "yes," please provide your Medicaid ID number ______________________

Do you or your spouse work? ☐ Yes ☐ No

Do you or your spouse have any health insurance other than Medicare, such as state insurance, Workers' Compensation or Veterans Administration (VA) benefits? ☐ Yes ☐ No
If you have other health insurance, what kind do you have? ______________________
What is the name of the health insurance? ______________________
Group # ______________________ ID#______________________

Enrollee's name ______________________
Proposed effective date ____ / ____ / ____

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Enrollment Form 1

7. Alternative formats (check only one)	
Please check one of the boxes if you would prefer us to send you information in a language other than English or in another format:	☐ Spanish ☐ Other ________________
Please contact Physicians Health Choice at 1-866-658-2053 if you need information in another format or language than those listed above. Our office hours are 7 a.m. – 9 p.m. local time, 7 days a week, 10/15 – 3/1; 7 a.m. – 9 p.m. local time, Monday – Friday, 3/2 – 10/14. TTY users should call 711.	

Statements of understanding

By completing this enrollment form, I agree to the following:

1. Physicians Health Choice Total (HMO) 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. For MA Only Plans, 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. 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.
2. Physicians Health Choice Total (HMO) serves a specific service area. If I move out of the area that Physicians Health Choice Total (HMO) 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 Physicians Health Choice Total (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Physicians Health Choice Total (HMO) 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.
3. By joining this Medicare health plan, I acknowledge that Physicians Health Choice Total (HMO) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Physicians Health Choice Total (HMO) 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.

Enrollee's name ____

Proposed effective date ____ / ____ / ____

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Statements of understanding (cont.)

By completing this enrollment form, I agree to the following:

4. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late-enrollment penalty. For more information about the late-enrollment penalty, I may visit www.medicare.gov or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
5. 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.

Physicians Health Choice Total (HMO)
I understand that beginning on the date Physicians Health Choice Total (HMO) plan coverage begins, I must receive all covered benefits from plan contracted providers and pharmacies, except for emergency or urgently needed services or out-of-area renal dialysis. I understand that authorized services and other services contained in my Evidence of Coverage document will be covered as disclosed. If I do not receive prior authorization as required for covered services, I understand that **neither Medicare nor Physicians Health Choice Total (HMO) will pay for services.**

Fraud warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Enrollment Form or files a claim containing a false or a deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

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8. Please read this important information

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 Enrollment Form means that I have read, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

You must sign and date this Individual Enrollment Form in order for it to be processed.

If signed by an authorized representative of the applicant, 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.

Signature of applicant/member/authorized representative	Today's Date ______/________/______

If you are the authorized representative of the applicant, you must provide the following information and sign above.

Name			Relationship to applicant
Address			Telephone Number ( )
City	State	ZIP Code	Alternate Phone Number (optional) ( )

9. For sales representative/agency use only

Selling Staff Member/Agent ID	Initial Receipt Date
Selling Staff Member/Agent Name	Proposed Effective Date
Agent Telephone Number	Did the agent assist in completing the application? ☐ Yes ☐ No
Agent Signature (required)	

10. Election period

☐ AEP
☐ ICEP
☐ IEP (MA or MA-PD enrollees)
☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEPI
☐ SEP (SEP Reason Code____)

Enrollee's name ____
Proposed effective date _____ / _____ / _____

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Attestation of 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.

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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. 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.

☐ 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 I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)________________________.

If none of these statements applies to you or you're not sure, please contact Physicians Health Choice at 1-866-658-2053 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 a.m. – 9 p.m. local time, 7 days a week, 10/15 – 3/1; 7 a.m. – 9 p.m. local time, Monday – Friday, 3/2 – 10/14.

Enrollee's name ________________________________

Proposed effective date _____ / _____ / _____

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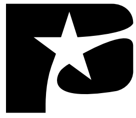


Physicians
Health Choice™

Receipt

Important Enrollment Information

Application Date ______________________________

Proposed Effective Date ______________________________

Medicare ID ______________________________

Plan Name ______________________________

Health Plan/PBP Number ______________________________

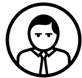
Sales Agent ID ______________________________

Sales Agent Name ______________________________

Sales Agent Phone Number ______________________________

This copy verifies you met with an agent who sells Physicians Health Choice Products. Once Physicians Health Choice receives the Enrollment Form, you will receive a copy of your original Enrollment Form in the mail within two weeks. This copy is for your records only. **Please do not resubmit.**

Please contact your sales agent if you do not receive a copy of your original Enrollment Form in the mail within two weeks.



Talk to your local sales agent for answers or to enroll.

If you do not have a local sales agent, please call **1-866-658-2053,** TTY **711,** 7 a.m. – 9 p.m. local time, 7 days a week, 10/15 – 3/1; 7 a.m. – 9 p.m. local time, Monday – Friday, 3/2 – 10/14.

Visit our website at:
www.PHCcares.com

www.PHCcares.com

This information is available for free in other languages. Please contact our Customer Service number at 1-866-658-2053, TTY/TDD: 711, 7 a.m. to 9 p.m. local time zone, 7 days a week 10/15 – 3/1: 7 a.m. to 9 p.m. local time zone, Monday – Friday 3/2 – 10/14, for additional information.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-866-658-2053, TTY/TDD: 711, del 15/10 al 01/03, los 7 días de la semana, de 7 a.m. a 9 p.m. hora local y del 02/03 al 14/10, de lunes a viernes, de 7 a.m. a 9 p.m. hora local, para obtener más información.

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