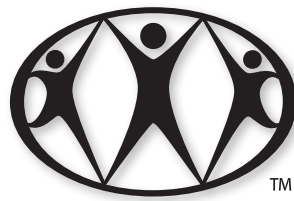


Enrollment Form



PUGET SOUND
HEALTH PARTNERS

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment)		Name of PCP				
Plan ID#	Member ID#			POD#		
Effective date of coverage	ICEP	IEP	OEP	AEP	SEP (type)	Not Eligible

ENROLLMENT FORM

Instructions: We cannot accept this application until you complete all of the following information.
You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

Personal Information

Please Check <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	Last Name (as it appears on Medicare card)	First Name	MI
Date of Birth (mm/dd/yyyy)	Home Phone (xxx-xxx-xxxx)	Alternate Phone (xxx-xxx-xxxx)	
Permanent Residence Address (Number, Street, Apt. #)	City	County	State
Mailing Address (Number, Street, Apt. #) if different from street address	City	County	State
		Zip	Zip

Medicare Insurance Information


Please take out your 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

Medicare Information: Fill in these blanks so they match your red, white and blue Medicare card.

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

MEDICARE

HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number _____ Sex _____

Is Entitled To: _____ Effective Date _____

Hospital Insurance (Part A)

Medical Insurance (Part B)

Your Medicare Advantage Plan Choice

1. Please check the plan you want to enroll in:

Plans WITH Prescription Drug Coverage

- Partners Sound Plus Rx (HMO): \$0 per month
- Partners Charter Plus Rx (HMO): \$70 per month
- Partners Apex Plus Rx (HMO): \$150 per month
- Partners Apex Plus Rx King County (HMO): \$160 per month
- Partners Summit Plus Rx (HMO-POS): \$180 per month

Plans with NO Prescription Drug Coverage

- Partners Charter (HMO): \$39 per month
- Partners Apex (HMO): \$89 per month
- Partners Apex King County (HMO): \$99 per month

PCP Name _____

Optional Supplemental Coverage

2. Please check the Optional Supplemental Coverage(s) you want to enroll in:

- Alternative: \$3 per month
- Dental: \$37 per month

Please Read and Answer These Important Questions:

- 1. Do you have End Stage Renal Disease (ESRD)?** No Yes If you answered "yes" to this question and you don't need regular dialysis anymore, 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 prescription 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 Puget Sound Health Partners (PSHP)?**
 No Yes 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?** No Yes
If "yes", please provide the following information:
Name of Institution: _____
Address (number and street) of Institution: _____
Phone Number of Institution: _____
- 4. Are you enrolled in your State Medicaid program?** No Yes If "yes", please provide
Medicaid number: _____
- 5. Do you or your spouse work?** No Yes

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

Language: _____ Format: (like Braille, audio tape or large print) _____

Please contact PSHP at 1-866-789-7747 (TTY users should call 1-866-264-4141) if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week.



Please Read the Important Information on Back BEFORE signing!

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 PSHP or by Medicare.

Your Signature: _____ **Date:** _____

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

Signature: _____ **Date:** _____

Name: _____ **Relationship to Enrollee:** _____

Address: _____ **Phone:** _____

Please Read This Important Information!

If you currently have health coverage from an employer or union, joining PSHP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PSHP. 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:

PSHP 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 only be in 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. 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: November 15 - December 31 of every year), or under certain special circumstances.

PSHP serves a specific service area. If I move out of the area that PSHP 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 PSHP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from PSHP when I receive 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 PSHP coverage begins, I must get all of my health care from PSHP physicians except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by PSHP and other services contained in my PSHP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR PSHP 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 PSHP he/she may be paid based on my enrollment in PSHP.

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.

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for in whole or in part, my enrollment in a Medicare Advantage or Medicare Prescription Drug plan.

Release of Information:

By joining this Medicare health plan, I acknowledge that PSHP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that PSHP 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.