




Please contact **Elderplan** if you need information in another language or format (Braille).
Individual Enrollment Request Form
 If you have questions, please contact **Elderplan** at 1-800-353-3765 or TTY 1-800-662-1220 seven days a week from 8:00 a.m. to 8:00 p.m.

PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN			
<input type="checkbox"/> Elderplan for Medicaid Beneficiaries (HMO SNP)	<input type="checkbox"/> Elderplan Plus Long Term Care (HMO SNP)		
<input type="checkbox"/> Elderplan Advantage for Nursing Home Residents (HMO SNP) \$36.40 per month	<input type="checkbox"/> Elderplan Medicaid Advantage (HMO SNP)		
<input type="checkbox"/> Elderplan Classic: Zero Premium (HMO)	<input type="checkbox"/> Elderplan Extra Help (HMO) \$36.00 per month		
	<input type="checkbox"/> Elderplan Independence Choice (HMO-POS)		
TO ENROLL IN ELDERPLAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:			
LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (MM / DD / YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate Phone Number: ()
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address):			
City:	State:	ZIP Code:	
Emergency Contact:	Phone Number:	Relationship to You:	
E-Mail Address:			
PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION			
Please take out your Medicare card to complete this section.			
<ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card – OR – Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. 		Name: _____ Medicare Claim Number _____ Sex: ____ Is Entitled To _____ Effective Date _____ HOSPITAL (Part A) _____ MEDICAL (Part B) _____	
You must have Medicare Part A and Part B to join a Medicare Advantage plan.			
PAYING YOUR PLAN PREMIUM			
If you have a plan premium AND/OR 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), 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.			
If you are assessed a Part D-Income related Monthly Adjustment Amount, 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 Elderplan 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 that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill.

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
 Account holder name: _____ Bank routing number: _____
 Bank account number: _____
 Account type: Checking Saving

Credit Card. Please provide the following information:
 Type of Card: _____ Name of Account holder as it appears on card: _____
 Account number: _____ Expiration Date: ___/___/___ (MM/YYYY)

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security or 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.)

 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.
- Some individuals may have other 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 **Elderplan**? Yes No
 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: _____
- Are you a resident in a long-term care facility, such as a nursing home? Yes No
 If "yes," please provide the following information:
 Name of Institution: _____
 Address & Phone Number of Institution (number and street): _____
- Are you enrolled in your State Medicaid program? Yes No
 If yes, please provide your Medicaid number: _____
- Do you or your spouse work? Yes No
- Elderplan for Medicaid Beneficiaries (HMO SNP): Please Check If Applicable**
 Are you eligible for Medicare cost-sharing assistance under New York State Medicaid? Yes No
- Elderplan Medicaid Advantage (HMO SNP): Please Check If Applicable**
 Are you eligible for full New York State Medicaid coverage? Yes No
- Elderplan Plus Long-Term Care (HMO SNP): Please Check If Applicable**
 Please indicate if you meet all the following requirements. 1) You are eligible for full New York State Medicaid coverage, 2) you are 18 years or older, and 3) you believe you are eligible for a nursing home level of care, are capable of safely remaining in your home, and require care management and home care or day care services for 120 days or longer? Yes No
- Elderplan Advantage for Nursing Home Residents (HMO SNP): Please Check If Applicable**
 Do you reside or expect to reside in a contracted nursing facility within the service area? Yes No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

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:

Spanish Braille Audio tape Large print

Please contact **Elderplan** at 1-800-353-3765 if you need information in another format or language than what is listed above. Our office hours are open seven days a week between the hours of 8:00 a.m. to 8:00 p.m. TTY users should call 1-800-662-1220.



If you currently have health coverage from an employer or union, joining Elderplan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Elderplan. 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 AND SIGN BELOW | |

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

Elderplan 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. 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.

Elderplan serves a specific service area. If I move out of the area that **Elderplan** 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 **Elderplan**, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from **Elderplan** 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 **Elderplan** coverage begins, I must get all of my health care from **Elderplan**, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by **Elderplan** and other services contained in my **Elderplan** Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ELDERPLAN WILL PAY FOR THE SERVICES.**

Elderplan for Medicaid Beneficiaries (HMO SNP): Please Check If Applicable
 I understand that Medicare has special enrollment rules for Elderplan for Medicaid Beneficiaries (HMO SNP). I understand that my Enrollment Form may be declined or I may be disenrolled if I am not eligible for Medicare cost-sharing assistance under New York State Medicaid.

Elderplan Medicaid Advantage (HMO SNP): Please Check If Applicable
 I understand that Medicare has special enrollment rules for Elderplan Medicaid Advantage (HMO SNP.) I understand that my Enrollment Form may be declined or I may be disenrolled if I am not eligible for Full New York State Medicaid.

Elderplan Plus Long Term Care (HMO SNP): Please Check If Applicable
 I understand that Medicare has special enrollment rules for Elderplan Plus Long-Term Care (HMO SNP). I understand that my Enrollment Form may be declined or I may be disenrolled if I am not eligible for Full New York State Medicaid, or if Elderplan is unable to confirm that I qualify for the Medicaid Advantage Managed Long Term Care program.

Elderplan Advantage for Nursing Home Residents (HMO SNP): Please Check If Applicable
 I understand that Medicare has special enrollment rules for Elderplan Advantage for Nursing Home Residents (HMO SNP). I understand that my Enrollment Form may be declined or I may be disenrolled if I do not reside, or expect to reside, in a contracted nursing facility within the service area.

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

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

Signature:	Today's Date:
If you are the authorized representative, you must sign above and provide the following information:	
Name : _____	
Address: _____	
Phone Number: (_____) _____ - _____	
Relationship to Enrollee: _____	
Office Use Only	
Name of staff member/agent/broker (if assisted in enrollment): _____	
Plan ID #: _____	Effective Date of Coverage: _____
ICEP/IEP: _____	AEP: _____ SEP (type): _____ Not Eligible: _____
Broker Application Receive Date: _____	

Please print all information in ink - keep the yellow copy for your records. Mail the white and pink copies (and any necessary payments) to: **Elderplan, 745 64th St. Brooklyn, NY 11220**