PEOPLES HEALTH

*Your **Medicare Health** Team*

A UnitedHealthcare Company

2022 Enrollment Request Form

☐ **Peoples Health Secure Health (HMO D-SNP) H1961-003-000**

Information about you. (Please type or print in black or blue ink)

Last Name	First Name	Middle Initial

Birth Date	Sex ☐ Male ☐ Female
Home Phone Number ( ) -	Mobile Phone Number ( ) -

Medicare Number

Permanent Residence Street Address **(P.O. Box is not allowed)**

City	Parish	State	ZIP Code

Mailing Address **(Only if it's different from above. You can give a P.O. Box.)**

City	State	ZIP Code

Email Address (optional)

Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If yes, what is it?

Name of Other Insurance

Member Number	Group Number	RxBin	RxPCN (optional)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

How do you want to pay?

Enrollee Name _____

Agent Name / ID No. _____

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If you have a monthly plan premium (including any late enrollment penalty you may owe) you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

If you don't choose an option below, we'll send a bill each month to your mailing address.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

☐ I want to pay from my Social Security

☐ I want to pay from my Railroad Retirement Board (RRB) check

☐ I want to pay directly from a bank account

Account Type ☐ Checking ☐ Savings
Account Holder Name: _____
Bank Routing Number __/__/__/__/__/__/__/__/__
Bank Account Number__/__/__/__/__/__/__/__/__/__

A few questions to help us manage your plan.

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No

Please check what you'd like: ☐ Spanish ☐ Braille ☐ Other_____

If you don't see the language or format you want, please call us toll-free at 1-855-269-0778, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.peopleshealth.com for online help.

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please give us your Medicaid number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

3. Do you or your spouse work? ☐ Yes ☐ No

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No

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If yes, please complete the following:

Name of Health Insurance Company

Member Number

4. Please give us the name of your primary care provider (PCP), clinic or health center.

You can find a list on the plan website or in the Provider Directory.

Provider or PCP Full Name

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Please read and sign.

By completing this form, I agree to the following:

- I must keep both Part A and Part B to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- I understand that when my Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health. Benefits and services authorized by Peoples Health and contained in my Peoples Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Peoples Health will pay for benefits or services**.
- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- **Release of Information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that

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Peoples Health will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes applicable to Federal law that authorize the collection of this information (see Privacy Act Statement below).

- ☐ I give Peoples Health permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- ☐ I give consent for all entities under Peoples Health and any outside vendor used by Peoples Health to call the phone number(s) I have provided.
- ☐ The information on this 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.
- ☐ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my member ID card, I can call Member Services at the number on my member ID card to update my authorization information on file.

Signature of Applicant/Member/Authorized Representative Today's Date

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If you are the authorized representative, please sign above and complete the information below.

***NOT A SALES AGENT**

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) –	Relationship to Applicant	

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For licensed sales representative/agency use only.

Employer Group Name

Employer Group ID	Branch ID
Licensed Sales Representative/Writing ID	Initial Receipt Date
Licensed Sales Representative/Agent Name	Proposed Effective Date

Agent must complete

☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)	☐ OEP (Jan1 – Mar 31)
☐ OEP (newly eligible)	☐ SEP (Dual LIS change of status)	☐ SEP (change in residence)	☐ SEP (loss of EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (October 15-December 7)	☐ OEPI

☐ SEP (SEP Reason) _____

Licensed Sales Representative Signature (optional) **Date:**

Please fax this completed form to:

Fax: 1-504-849-6958

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

OMB No. 0938-1378
Expires: 7/31/2023

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Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the Benefits

- ✔ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✔ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✔ Review the Provider Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ✔ You must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- ✔ Benefits may change on January 1 of each year.
- ✔ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ✔ This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.