

**INSTRUCTIONS for COMPLETING  
Optima Medicare HMO Enrollment Request Form**

**IMPORTANT:** Please **PRINT** information in pen and **DO NOT SKIP** any steps. Fill all information in as completely as possible.

**STEP 1: To Enroll in Optima Medicare HMO section:**

Select which Optima Medicare plan you are requesting – Value or Prime. Complete all of the required personal information.

Helpful Hints:

“*Alternate Phone Number*” means a cell or business phone.

“*Email Address*” allows us to contact you electronically.

“*Mailing Address*” means a street address where you receive your mail. Complete only if it is different from your Permanent Residence Address.

“*Emergency Contact Name*” means the person we should notify in an emergency.

**STEP 2: Please Provide Your Medicare Insurance Information section:**

Copy this information from your red, white, and blue Medicare Card.

**STEP 3: Paying Your Plan Premium and/or Late Enrollment Penalty (LEP) section:**

Complete the payment method for paying your plan premium and the Late Enrollment Penalty, if any, for Part D benefits.

**STEP 4: Please Read and Answer These Important Questions section:**

Complete these medical and prescription drug coverage questions. Answer Yes or No to each question and provide additional information as instructed.

**STEP 5: Eligibility Attestation for Enrollment section:**

Complete this section based on your reason for enrolling in Optima Medicare.

**STEP 6: STOP Please Read The Important Information On The Back Of This Application and Sign Below section:**

**SIGN and DATE** the application. You must use the current date. If you are a Legal Representative completing the form on behalf of the Medicare beneficiary, complete the Legal Representative section and attach the Power of Attorney or other document that supports your status as Legal Representative.

**STEP 7: Please Read Below section:**

Carefully review the information on page 4 of the Enrollment Request Form.



## 2017 Optima Medicare HMO Enrollment Request Form

Check one if you need plan information in another format:  Large print  Audio  Braille  
 Contact Optima Medicare at 1-855-547-7740 (TTY Call 711) if you need information in another format or language than what is listed above. Our office hours are 8 a.m. - 8 p.m., seven days a week.

### To Enroll in Optima Medicare HMO, Please Provide the Following Information:

Please check which plan you want to enroll in:  Optima Medicare Value: \$0 per month (with prescription drugs)  
 Effective Date Requested: \_\_\_\_\_  Optima Medicare Prime: \$39 per month (with prescription drugs)

Mr.  Mrs.  Ms.      FIRST Name:                      Middle Initial:                      LAST Name:

Birth Date: (MM/DD/YYYY)      Sex:  M  F      Home Phone Number: (      )  
 Alternate Phone Number: (      )

Email Address: \_\_\_\_\_  
 I give Optima Health permission to send my plan materials and member communications, excluding EOBs, by email.

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

City or County:                      State: VA                      ZIP Code:

Mailing Address - Street Address/P.O. Box: **(only if different from your Permanent Residence Address):**                      Apt. #

City or County:                      State:                      ZIP Code:

Emergency Contact Name:                      Relationship to you:

Emergency Contact Phone Number:


Please select a Primary Care Physician from our 2017 Provider Directory:

### Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- 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.

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

|                       |  |   |                         |  |
|-----------------------|--|---|-------------------------|--|
| <b>MEDICARE</b>       |  |  | <b>HEALTH INSURANCE</b> |  |
| SAMPLE ONLY           |  |   |                         |  |
| Name: _____           |  |   |                         |  |
| Medicare Claim Number |  |   | Sex: _____              |  |
| _____ - _____ - _____ |  |   |                         |  |
| Is Entitled to:       |  |   | Effective Date          |  |
| HOSPITAL (Part A)     |  |   | _____                   |  |
| MEDICAL (Part B)      |  |   | _____                   |  |

**Paying Your Plan Premium and/or Late Enrollment Penalty (LEP):**

If we determine that you owe a Late Enrollment Penalty (LEP), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT) each month, or by automatic deduction from your monthly Social Security Benefit or Railroad Retirement Board (RRB) benefit check. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-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 Optima Medicare HMO.

Please provide any non-Medicare pharmacy plan information for drug coverage you have had since becoming eligible for Medicare Part D benefits to determine whether you may be charged a LEP.

Plan Name \_\_\_\_\_ Policy Number \_\_\_\_\_ Beginning/Ending Date \_\_\_\_\_

**Please select a Premium Payment or LEP option:**

If you have a premium payment or LEP and do not select a payment option, you will receive a bill each month.

- Receive a monthly bill
- Electronic Funds Transfer (EFT) from your bank checking or savings account each month. Please enclose a VOIDED check or deposit slip, and provide the following in order for your auto deduction to be processed:  
 Account holder name: \_\_\_\_\_  
 Bank routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_
- Automatic deduction from your monthly Security or RRB benefit check. The Social Security /RRB deduction may take several months to begin. Please be aware, if the withholding does not start at time of enrollment, you will be responsible for payment until withholding begins. You will receive a bill.

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](http://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 does not cover.

**Please Read and Answer These Important Questions:**

1. Do you have End Stage Renal Disease?  Yes  No  
If you answered "yes" to this question and you don't need regular dialysis any more, 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. Do you or your spouse work?  Yes  No

3. Do you currently have any other medical coverage, including other **private insurance, VA benefits, Medicaid, TRICARE,** or **Federal Employee Health Benefits** coverage?  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: | Ending Coverage Date: |
| _____                   | _____                  | _____                      | _____                 |
| _____                   | _____                  | _____                      | _____                 |

Will you have any other **prescription drug coverage** in addition to Optima Medicare HMO?  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: | Ending Coverage Date: |
| _____                   | _____                  | _____                      | _____                 |

**Eligibility Attestation for Enrollment:**

This certifies that, to the best of your knowledge, you are eligible to enroll at this time. You may be disenrolled if this information is incorrect. Please review and check any of the following statement(s) that apply:

- Eligible for Annual Enrollment Period
  - Recently involuntarily lost creditable/prescription coverage: \_\_\_\_\_ (date)
  - Newly eligible to Medicare Part A and/or Part B: \_\_\_\_\_ (date)
  - Receive extra help paying for your Medicare prescription drugs: \_\_\_\_\_ (date)
  - Leaving your employer or union coverage: \_\_\_\_\_ (date)
  - No longer eligible for extra help paying for prescription drugs: \_\_\_\_\_ (date)
  - Recently moved and this plan is now an option: \_\_\_\_\_ (date)
  - Recently moved outside of the area your plan covers: \_\_\_\_\_ (date)
  - Recently left a PACE program: \_\_\_\_\_ (date)
  - Your Plan is ending its contract with Medicare
  - Belong to a State Pharmacy Assistance Program
  - Recently released from incarceration. \_\_\_\_\_ (date)
  - Moved back to the United States: \_\_\_\_\_ (date)
  - Recently obtained lawful presence status in the U.S. \_\_\_\_\_ (date)
  - Have Medicaid or the state helps pay for your Medicare. Medicaid Number: \_\_\_\_\_
  - Moving in, live in, or recently moved out of a Long-Term Care Facility (nursing home): \_\_\_\_\_ (date)  
Name of Institution: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address of Institution (number and street): \_\_\_\_\_
  - No longer eligible for Special Needs Plan and was disenrolled: \_\_\_\_\_ (date)
- Other (please indicate reason): \_\_\_\_\_

If these do not apply, please contact Optima Medicare HMO 1-855-547-7740 (TTY call 711), to see if you are eligible to enroll, 8 a.m. - 8 p.m., seven days a week.



**Please Read The Important Information On The Back Of This Application (see page 4) and Sign Below.**

**If you currently have health coverage from an employer or union, joining Optima Medicare HMO could affect your ability to keep your employer or union health coverage. You could lose your employer or union health coverage if you join Optima Medicare HMO.** 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

I understand that my signature (or the signature of the legal representative 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, including the agreement on the back. 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 Optima Medicare HMO or by Medicare.

|                         |                            |
|-------------------------|----------------------------|
| <b>Signature:</b> _____ | <b>Today's Date:</b> _____ |
|-------------------------|----------------------------|

Legal Representative: Sign above, provide information below and **submit documentation of legal authority:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Relationship to Enrollee:** \_\_\_\_\_

**Agent Use Only:** Agent Name (please print): \_\_\_\_\_ Agent NPN#: \_\_\_\_\_

**Please Read Below**

Optima Medicare HMO is a Medicare Advantage plan and has a contract with the Federal government.

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

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. I understand that if I do not 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 (For example: October 15 - December 7 of every year), or under certain special circumstances.

Optima Medicare HMO serves a specific service area. If I move out of the area that Optima Medicare HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that people with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Once I am a member of Optima Medicare 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 Optima Medicare HMO when I receive it to know which rules I must follow to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Optima Medicare HMO coverage begins, I must get all of my health care from Optima Medicare HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Optima Medicare HMO and other services contained in my Optima Medicare HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR OPTIMA MEDICARE HMO WILL PAY FOR THE SERVICES.**

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

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

**Office Use Only:**

Plan ID #: \_\_\_\_\_ **Effective Date of Coverage:** \_\_\_\_\_

ICEP/IEP    AEP   SEP (type): \_\_\_\_\_