Amerivantage Dual Coordination (HMO SNP)

Individual Enrollment Request Form — 2019

Be sure to complete the entire enrollment form. Then, **mail** the completed form to **P.O. Box 659403 San Antonio TX, 78265-9714** ***or*** **fax** the completed form to **1-800-833-8554**. You can also enroll online at **https://shop.amerigroup.com/medicare.** ***Note:*** Your agent/broker may provide different instructions.

Please contact Amerigroup if you need information in another language or format (Large Print or Braille).

Please check which plan you want to enroll in.			
☐ **Amerivantage Dual Coordination (HMO SNP)** **$0.00 per month**			
Last name		**First name**	**MI**
Birthdate (MM/DD/YYYY)	**Gender** ☐ M ☐ F	**Home phone number**	**Alternate phone number**
Permanent residence street address (P.O. Box is not allowed.)			
City	State	ZIP code	County
Mailing address (only if different from your permanent residence address)			
City	State	ZIP code	

Please provide your Medicare insurance information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ 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.

Applicant Complete: Name _____ and Medicare Number _____

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Paying your plan premium

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty that you currently have or may owe, and the optional supplemental benefit plan premium, if you enrolled in that plan) by mail or electronic funds transfer (EFT) 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 (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 Railroad Retirement Board (RRB). DO NOT pay Amerigroup 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 coinsurance. 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 also can 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 choose one of the options below:

☐ **Monthly Bill:** Send me a bill each month

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your ***first*** payment.) Please complete steps 1 and 2 below:

1) Account Type ☐ **Checking:** Must enclose a **VOIDED check**. ☐ **Savings:** Must enclose letter from financial institution with account information.

2) Please complete the following information for your account

Account holder name _____ Account number _____

Bank routing number* _____ Bank name _____

(*This is the first 9 digits printed on the lower left corner of your check.)

I authorize the bank above to deduct my monthly premiums

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

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/Railroad Retirement Board (RRB) deduction may take two or more months to begin after Social Security or Railroad Retirement Board (RRB) approves the deduction. In most cases, if Social Security or Railroad Retirement Board (RRB) accepts your request for automatic deduction, the first deduction from your Social Security or Railroad Retirement Board (RRB) benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or Railroad Retirement Board (RRB) delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Applicant Complete: Name _____ and Medicare Number _____

Please read and answer these important questions:

1. **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.

2. **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 your current prescription drug coverage be ending? ☐ Yes ☐ No ☐ N/A

Will you continue to have other prescription drug coverage? ☐ Yes ☐ No ☐ N/A

If "yes," please list your other coverage and your identification (ID) # for this coverage

Dates Covered: **Start** ___ ___ _____ **End** ___ ___ _____ 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?** ☐ Yes ☐ No

If "yes," please provide the following information:

Name of institution _____

Address _____

City _____ State _____ ZIP code _____ Phone number _____

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

If "yes," please provide your Medicaid number _____

5. **Do you or your spouse work?** ☐ Yes ☐ No

6. **Please choose the name of a primary care physician (PCP).** If you do not choose a PCP, one will be selected for you.

PCP ID # (as shown in the Provider Directory) _____

PCP name _____ _____
First Name Last Name

Primary Medical Group (PMG) name _____

PCP address _____

City _____ State _____ ZIP code _____

New physician for you? ☐ Yes ☐ No

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

☐ Spanish

Assistance for the visually impaired:

☐ Voice-Enabled (Audio) PDF ☐ Large Print

Please contact Amerivantage Dual Coordination (HMO SNP) at **1-844-765-5165** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users should call **711**.

enrollment form

Applicant Complete: Name _____ and Medicare Number _____

STOP

Please read this important information.

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

Typically, you may enroll in a Medicare Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year or during the Open Enrollment Period (OEP) between January 1 to March 31. Beneficiaries enrolled in a MA-PD plan may use the OEP to switch to another MA-PD plan; a MA-only plan; or Original Medicare with/without a PDP. Additionally, there are exceptions — i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that 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.

NOTE: You must select at least one of the options below.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- ☐ I am new to Medicare. (IEP/ICEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ 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) _____ . (SEP)
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. (SEP)
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____. (SEP)
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____. (SEP)
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. (SEP)
- ☐ I recently had a change in my Extra Help paying for my Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____ . (SEP)
- ☐ 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)_____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date)_____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ . (SEP)
- ☐ I am leaving employer or union coverage on (insert date) _____ . (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____. (SEP)
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)

Applicant Complete: Name _____ and Medicare Number _____

☐ 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) _____ . (SEP)

☐ I was recently released from incarceration. I was released on (insert date)_____. (SEP)

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____. (SEP)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)

☐ Other* _____

*Please contact Amerigroup at **1-844-765-5165.** Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. (TTY users should call **711**) to see if you are eligible to enroll.

Email Preferences

Email is the fastest, easiest way to get important information about your plan – and some fun extras, too! Please provide your email address below to sign up for our e-mail program.

Member's email **@** _____

By giving my email address, I agree to receive emails about my benefits, health programs and other plan services.

I understand I can change my email preferences any time by calling customer service.

Please read and sign in the "Applicant signature" box below

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

Amerivantage Dual Coordination (HMO SNP) 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 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 (for example, October 15 – December 7 of every year), or under certain special circumstances.

Amerivantage Dual Coordination (HMO SNP) serves a specific service area. If I move out of the area that Amerigroup 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 Amerivantage Dual Coordination (HMO SNP) , I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Amerigroup 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 usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Amerigroup coverage begins, I must get all of my health care from Amerigroup participating providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Amerigroup and other services contained in my Amerivantage Dual Coordination (HMO SNP) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AMERIGROUP 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 Amerigroup, he/she may be paid based on my enrollment in Amerivantage Dual Coordination (HMO SNP) .

Applicant Complete: Name _____ and Medicare Number _____

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

Applicant signature X	**Today's date**
Desired plan effective date*:	

*Subject to Medicare election period guidelines

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name		
Address First Name	Last Name	
City	**State**	**ZIP code**
Phone Number	**Relationship to Enrollee**	

enrollment form

Applicant Complete: Name _____ and Medicare Number _____

Applicant: Please do not complete the following sections.
Agent/Broker: **Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.**

Coverage effective date _____ PLAN ID #: _____

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP (type): _____ ☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No DSNP Verification Code _____

Was this an individual face-to-face appointment? ☐ No ☐ Yes (if yes, how was a scope of appointment (SOA) collected)? ☐ Paper ☐ Recorded call (voice recording ID) _____

Print name _____ _____
First Name Last Name

Writing Agent TIN (10 digits)/Agent Code___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Agency TIN (10 digits) or Agency Code___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Agency Name _____

Street address _____

City _____ State _____ ZIP code _____

Phone _____ Fax _____

Email @ _____

Signature _____ Application received date _____

Amerigroup Texas, Inc. is an HMO DSNP plan with a Medicare contract and a contract with the State Medicaid program. Enrollment in Amerigroup Texas, Inc. depends on contract renewal.

ATENCIÓN: Si habla español, los servicios de asistencia lingüística están disponibles sin costo alguno para usted. Llame al 1-844-765-5165 (TTY: 711).

Applicant Complete: Name _____ and Medicare Number _____