



To Enroll in Central Health Medicare Plan, Please Provide the Following Information :

Please Print

Please check which plan you want to enroll in:

_____ Central Health **Medicare** Plan (001)

_____ Central Health **Medi-Medi** Plan (002)

LAST NAME :

FIRST NAME :

Middle Initial

Mr. Mrs. Ms.

Birth Date :

(__ __ / __ __ / __ __ __ __)
(M M / D D / Y Y Y Y)

Sex : M

F

Social Security Number :

(this information is optional)

Home Phone Number :

()

Permanent Residence Street Address :

City :

State :

ZIP Code :

Mailing Address (only if different from your Permanent Residence Address) :

Street Address : _____

City : _____ State : _____ ZIP Code : _____

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 the Social Security Administration or Railroad Retirement Board.

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 : <input type="checkbox"/> M <input type="checkbox"/> F	
_____ - _____ - _____ - _____				
Is Entitled To			Effective Date	
HOSPITAL (PART A)			_____	
MEDICAL (PART B)			_____	

Paying Your Plan Premium:

If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail by the 5th of each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

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

Please select a premium payment option :

- Receive a monthly bill
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins).

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "YES" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

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 you have other prescription drug coverage in addition to Central Health Medicare Plan? 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 : _____

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 : _____ Phone Number : _____

Address of Institution (number and street) : _____

4. Are you enrolled in your State Medicaid (Medi-Cal) program? Yes No

If yes, please provide your Medi-Cal number : _____

5. Do you or your spouse work? Yes No

Please choose the name of a Primary Care Physician (PCP) and Physician Group (optional) :

Name of PCP : _____ Physician Group (spell out completely) : _____

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 Chinese Braille

Please contact Central Health Medicare Plan at 1-866-314-2427 (TTY users should call 1-888-205-7671) if you need information in another format or language than what is listed above. Our office hours are 7 days a week, 8 AM - 8 PM.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining Central Health Medicare Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Central Health Medicare Plan may change how your current coverage works. 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.

Please Read and Sign Below:

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

Central Health Medicare Plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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: November 15 - December 31 of every year), or under certain special circumstances.

Central Health Medicare Plan serves a specific service area. If I move out of the area that Central Health Medicare Plan 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 Central Health Medicare Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Central Health Medicare Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Central Health Medicare Plan coverage begins, I must get all of my health care from Central Health Medicare Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Central Health Medicare Plan and other services contained in my Central Health Medicare Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CENTRAL HEALTH MEDICARE PLAN 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 Central Health Medicare Plan, he/she may be compensated based on my enrollment in Central Health Medicare Plan.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Plan 001 only: By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of 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 drug plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Central Health Medicare Plan 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 behalf of the individual under the laws of the State where the individual resides) 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 Central Health Medicare Plan or by Medicare.

Signature :	Today's Date :
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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

I hereby attest that I have complied with CMS Medicare Marketing Guidelines for MAPDs and Central Health Medicare Plan policies in this enrollment.

Name of staff member/agent/broker (if assisted in enrollment) : _____

Signature of staff member/agent/broker (if assisted in enrollment) : _____

License # : _____ Plan ID # : _____

Application Receive Date : _____ Effective Date of Coverage : _____

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