



CENTRAL HEALTH PLAN OF CALIFORNIA

Membership Application

1540 Bridgegate Drive
Diamond Bar, CA 91765

Please contact Central Health Medicare Plan (HMO) if you need information in another language or format (Braille).

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

Please Print

Please check which plan you want to enroll in:

_____ Medicare Plan (001) _____ Medi-Medi Plan (002) _____ Value Plan (003)

LAST NAME :	FIRST NAME :	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	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) :

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 the Railroad Retirement Board.

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

	
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 benefit check each month.

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 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 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 of 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 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 if you 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) :

First _____ Middle _____ Last _____

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 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. (TTY users should call 1-888-205-7671).



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. *You could lose your employer or union health coverage if you join Central Health Medicare Plan.* 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:

Central Health Medicare Plan 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: 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 document from Central Health Medicare Plan 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 are not 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 Central Health Medicare Plan coverage begins, I must get all of my health care from Central Health Medicare Plan, except for 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 getting assistance from a sales agent, broker, or other individual employed by or contracted with Central Health Medicare Plan, he/she may be paid based on my enrollment in Central Health Medicare Plan.

Plan 001 only: By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy 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 Prescription Drug Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Central Health Medicare 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 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 by Central Health Medicare Plan or by 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

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 :** _____