

UPMC *for Life*

UPMC Health Plan Medicare Program

How to Enroll in the UPMC *for Life* HMO/PPO Plans APPLICATION INSTRUCTIONS:

General Instructions:

Please fill out each section of the enclosed application completely. **All information must be completed and the application signed, in order for your enrollment form to be processed.**

If you need assistance with your Enrollment Application, contact us at 1-877-381-3765, seven days a week from 8 a.m. to 8 p.m. TTY/TTD users should call 1-800-361-2629.

Note: From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.

You may enroll in a Medicare Advantage Plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Section 1 – Name and Address Information: Complete your name and address information. The permanent address field must be your physical street address. Please do not list a P.O. box address in the permanent address field.

Section 2 – Medicare Information: Provide your name, Medicare Claim number, and effective dates (Parts A and B) exactly as they appear on your red, white, and blue Medicare identification card. You must have Medicare Part A and Part B to join a Medicare Advantage Plan. Your application cannot be finalized until UPMC *for Life* has your Medicare Claim number and effective dates of coverage.

Section 3 - Benefit Plan Option and Premium Payment Option: Select one UPMC *for Life* benefit plan option (HMO/PPO) and the method by which you would like to pay your premium.

Section 4 - Primary Care Physician Selection (HMO Plan Only): If you choose one of our HMO plans, you will need to select a primary care physician (PCP) to coordinate your care. Please indicate the PCP name, and 4-digit PCP number, which you can obtain from the UPMC *for Life* provider directory included in this packet.

Sections 5 and 6 – Other Health Insurance Information and Questions: If you have other health or prescription drug coverage, please provide this information. Also provide answers to the questions in Section 6 regarding end-stage renal disease and long-term care facility residence.

Sign and Date the Application: After you have read the UPMC *for Life* Rights and Responsibilities statements carefully and completed the enrollment application, please sign and date the application where indicated.

UPMC *for Life* Rights and Responsibilities

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

- (a) I understand that if I currently have health coverage from an employer group or union, joining this plan may change how my current coverage works. I will read the communications my employer group or union sends me. If I have questions, I will visit their website or contact the plan benefits administrator listed in their communications.
- (b) UPMC *for Life* is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Parts A and B coverage. I understand that I can be a member of only one Medicare Advantage plan at a time and that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan.
- (c) I understand it is my responsibility to inform UPMC *for Life* of any prescription drug coverage that I have or may get in the future through another plan. 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 a Medicare prescription drug coverage in the future.
- (d) I understand that 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.
- (e) UPMC *for Life* serves a specific service area. I understand that if I move permanently out of the service area, I need to notify the plan so I can disenroll and find a new plan in my new area.
- (f) I understand that, as a member of UPMC *for Life*, I have the right to appeal plan decisions about payments, services, or prescriptions if I disagree. I will read the Evidence of Coverage document from UPMC *for Life* when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.
- (g) **HMO Plans Only:** I understand that beginning on the date UPMC *for Life* coverage begins, I must get all of my health care from UPMC *for Life*, with the exception of emergency or urgently needed care services or out-of-area dialysis services. Services authorized by UPMC *for Life* and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. If a service requires an authorization and one is not obtained, **NEITHER MEDICARE NOR UPMC *for Life* WILL PAY FOR THE SERVICES.**
- (h) **PPO Plan Only:** I understand that if I receive covered services from a provider outside of the UPMC *for Life* network, with the exception of emergency or urgently needed care services or out-of-area dialysis services, those services may be subject to a deductible, coinsurance, and/or balance billing from the provider. The out-of-network cost sharing may be higher than in-network because the coinsurance is based on the Medicare allowed amount and not the potentially lower contracted amount. For more details, please refer to your Evidence of Coverage.
- (i) **I understand that when I am enrolled in UPMC *for Life* Medicare Advantage Prescription Drug Plan, I will receive my Medicare prescription drug coverage through this plan. I do not need to enroll in a separate Prescription Drug Plan (PDP).**
- (j) I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with UPMC *for Life*, he or she may be compensated based on my enrollment in this plan.
- (k) 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 (Medical Assistance) program and the Medicare Savings Program.

Continued

- (l) **Release of Information:** By joining this plan, I acknowledge that UPMC *for Life* will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UPMC *for Life* will release my information, including my prescription drug event data (if applicable), to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.
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Please read the following statements carefully and check all of the boxes to the left of the statements that apply to you. By checking any of the 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. If you have questions about your enrollment in our Plan contact UPMC *for Life* at the phone numbers provided below.

- I am new to Medicare.
 - I am either losing or leaving my employer or union group coverage.
 - I recently moved outside of the service area of my current plan.
 - I recently moved and this plan is a new option for me.
 - I recently returned to the United States after living permanently outside of the U.S.
 - I live in or recently moved out of a long-term care facility (e.g., nursing home).
 - I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
 - I recently left a Program for All Inclusive Care for the Elderly.
 - I receive extra help paying for Medicare prescription drug coverage.
 - I belong to a pharmacy assistance program provided by the state (e.g., PACE).
 - I recently left a pharmacy assistance program (e.g., PACE).
 - I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare).
 - I am no longer eligible for extra help paying for my Medicare prescription drugs.
 - None of these statements apply to me.
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Please check one of the boxes below if you would prefer us to send you information in an alternative format or contact our Plan for another format, not listed, at the phone numbers provided below:

- Language, other than English; please list _____
 - Large Print
 - Braille
 - Audiotape
-

For questions about this application call UPMC *for Life* at 1-877-381-3765, seven days a week from 8 a.m. to 8 p.m. TTY/TTD users should call 1-800-361-2629. (From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.)

UPMC *for Life*

UPMC Health Plan Medicare Program

2009 INDIVIDUAL ENROLLMENT APPLICATION - Pennsylvania

If you have questions about this form, please call us at 1-877-381-3765. TTY/TDD users should call 1-800-361-2629.

OFFICE USE ONLY	
Plan ID#:	Effective Date:
ICEP/IEP:	OEP:
AEP:	SEP (type):
Not Eligible:	
Prior Plan, if applicable:	
Plan Representative/Broker:	
If you assisted with application, sign and date here.	
Application Mailed: <input type="checkbox"/>	Faxed: <input type="checkbox"/>

I. TO ENROLL, PLEASE PROVIDE THE FOLLOWING INFORMATION

Name: First	M.I.	Last	Telephone #: ()
Date of birth: / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: (Optional)	
Permanent address (Street, Apartment #):	City:	State:	Zip code: County:
Mailing address (Street, Apartment #):	City:	State:	Zip code: County:
E-mail address: (Optional):			

2. MEDICARE INFORMATION

Please fill in the card to the right with the information from your Medicare card. Otherwise, please attach a copy of your Medicare card or your Letter of Verification from Social Security (or from the Railroad Retirement Board). You must have Medicare Parts A and B to join our Plan. **We cannot consider your enrollment finished until you have given us this information.**

MEDICARE HEALTH INSURANCE	
Sample Only	
Name of beneficiary:	_____
Medicare claim number:	_____
Is entitled to:	Effective date:
<input type="checkbox"/> Hospital Insurance (Part A)	_____
<input type="checkbox"/> Medical Insurance (Part B)	_____

3. SELECT A UPMC *for Life* BENEFIT PLAN OPTION AND PREMIUM PAYMENT OPTION

The plan below **DOES NOT INCLUDE** prescription drug coverage:
 UPMC *for Life* HMO (\$0/month)
 The following plans **INCLUDE** prescription drug coverage:
 UPMC *for Life* HMO Rx (\$28.50/month)
 UPMC *for Life* HMO Rx Enhanced (\$109.00/month)
 UPMC *for Life* PPO Rx Enhanced (\$165.60/month)
 Your signature on this application confirms that you have reviewed and understand the plan benefits and premium, if applicable, for the plan you have selected above.

PLAN PREMIUM INFORMATION
 We will send you a bill each month which you can pay by check, Electronic Funds Transfer (EFT), or credit card. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

I would like to pay my monthly plan premium (if applicable) by:
 Check EFT Credit Card
If you elected to pay your premium by credit card or EFT, please complete the enclosed Payment Election Form and return it with your application.
 Automatic deduction from my monthly Social Security benefit check. (The Social Security deduction, if approved, 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.)
Note: If you qualify for extra help with your Medicare prescription drug coverage costs and Medicare only pays a portion of this premium, we will bill you for the portion that Medicare does not cover.

4. SELECT A PRIMARY CARE PHYSICIAN (PCP) – HMO PLAN ONLY

Name of selected PCP: _____ PCP # (from enclosed provider directory): _____
 Are you currently a patient of this physician? Yes No

5. OTHER HEALTH INSURANCE INFORMATION

1) Are you or your spouse currently employed full time? Yes No
Are you receiving group health insurance through your or your spouse’s employer? Yes No

2) Will you have other medical coverage in addition to UPMC *for Life*? Yes No
If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name: ID number:

Insurance company phone: Group number:

Subscriber name: Subscriber date of birth:

3) Do you receive Medicaid benefits? Yes No
If “yes,” please provide your Medicaid #: _____

Some individuals may have other **drug coverage**, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs (e.g., PACE).

4) Will you have other prescription drug coverage in addition to UPMC *for Life*? Yes No
If “yes,” please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name:

ID number: Group number:

6. PLEASE READ AND ANSWER THESE QUESTIONS

(a) Do you have End Stage Renal Disease (ESRD)? Yes No
If “yes,” you are not eligible to enroll in this plan unless you are currently enrolled in a UPMC Health Plan commercial product OR you were enrolled (with ESRD) in a Medicare Advantage plan that no longer provides coverage for the area where you live. If you have had a successful kidney transplant, and/or you no longer need regular kidney dialysis, please provide documentation in the form of a note or records from your doctor.

Your answers to the following questions will NOT keep you from enrolling in this plan.

(b) Are you a resident in a long-term care facility, such as a nursing home? Yes No

(c) **I completed this application with assistance from a UPMC Health Plan representative.**

face-to-face meeting **telephone call** **completed by myself**

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 reside) 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 UPMC *for Life* or by Medicare. **Your signature on this application means that you have reviewed and understand the plan benefits/premium and Rights and Responsibilities listed at the beginning of this form.**

Signature: _____ Date: _____

If you are the **authorized representative**, you must sign above and provide the following information.

Name: _____ Relationship to enrollee: _____

Address: _____ Phone number: _____

Please return the **WHITE COPY** to UPMC *for Life* in the **postage-paid envelope** provided. **Please keep the Yellow Copy for your records.** Or you can fax the information to UPMC *for Life* at 412-454-7766. Our mailing address is UPMC *for Life*, P.O. Box 2967, Pittsburgh, PA 15230.

White copy to: UPMC *for Life*

Yellow copy to: MEMBER