

UPMC *for Life* Specialty Plan

UPMC Health Plan Medicare Program

How to Enroll in the UPMC *for Life* Specialty Plan

INDIVIDUAL ENROLLMENT APPLICATION

APPLICATION INSTRUCTIONS: In order for your enrollment to be processed, please fill out each section completely. All information must be completed and the application signed. If you would like assistance with your UPMC *for Life* Specialty Plan enrollment application, please contact us at 1-866-405-8762, seven days a week from 8:00 a.m. to 8:00 p.m. TTY/TDD users should call 1-866-407-8762.

(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).

Important reminder: You must have Medicare Parts A and B and full Medical Assistance coverage at the time of enrollment to be eligible to enroll in this plan.

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 Medicare identification card. Your application cannot be finalized until UPMC *for Life* Specialty Plan has your Medicare claim number and effective dates of coverage.

Section 3 – Primary Care Physician Selection: 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* Specialty Plan provider directory included in this enrollment packet.

Section 4 – Other Health Insurance Information: If you have other health or prescription drug coverage, please provide this information.

Section 5 – Other Questions: Provide answers to questions regarding end-stage renal disease and long-term care facility residence and if a UPMC Health Plan Representative assisted you in filling out the enrollment application.

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

Continued 

UPMC *for Life* Specialty Plan 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 or union, joining UPMC *for Life* Specialty Plan could affect my employer or union health benefits. If I have health coverage from an employer or union, joining UPMC *for Life* Specialty Plan may change how my current coverage works. I read the communications my employer or union sends me. If I have questions, I will visit their website, or contact the office listed in their communications. If there is no information on whom to contact, my benefits administrator or the office that answers questions about my coverage can help.
- (b) UPMC *for Life* Specialty Plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B coverage.
- (c) 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.
- (d) I understand that it is my responsibility to inform UPMC *for Life* Specialty Plan of any prescription drug coverage that I have or may get in the future through another plan.
- (e) I understand that it is my responsibility to tell UPMC *for Life* Specialty Plan before I move out of the 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* Specialty Plan, I have the right to appeal plan decision about payment or services if I disagree. I will read the Evidence of Coverage Document from UPMC *for Life* Specialty Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.
- (g) I understand that, beginning on the date my UPMC *for Life* Specialty Plan coverage begins, I must get all of my health care services from the UPMC *for Life* Specialty Plan network providers, with the exception of emergency or urgently needed services or out-of-area dialysis services. I understand that services authorized by UPMC *for Life* Specialty Plan and other services contained in my UPMC *for Life* Specialty Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, **NEITHER MEDICARE NOR UPMC *for Life* Specialty Plan WILL PAY FOR THE SERVICES.**
- (h) I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with UPMC *for Life* Specialty Plan, he/she may be compensated based on my enrollment in UPMC *for Life* Specialty Plan.
- (i) 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.
- (j) **Release of Information:** By joining this Medicare health plan, I acknowledge that UPMC *for Life* Specialty Plan 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* Specialty 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.

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INDIVIDUAL ENROLLMENT APPLICATION

If you have questions about this form, please call us at 1-866-405-8762. TTY/TDD users should call 1-866-407-8762.

OFFICE USE ONLY	
Plan ID#:	Effective Date:
ICEP/IEP:	OEP:
AEP:	SEP (type):
Not Eligible:	
Prior Plan, if applicable:	
Plan Representative:	
If you assisted with application, sign and date here.	

I. TO ENROLL, PLEASE PROVIDE THE FOLLOWING INFORMATION

Name: First	M.I.	Last	Telephone #: ()
Date of birth: / /	Sex: <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:
Person to contact in an emergency:	Emergency phone #:	Relationship to you:	
E-mail address: (Optional):			
Please check one of the boxes below if you would prefer us to send you information in an alternative format:			
<input type="checkbox"/> Language, other than English; please list _____		<input type="checkbox"/> Large Print	
<input type="checkbox"/> Audio Tapes		<input type="checkbox"/> Braille	

2. MEDICARE 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

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: _____

Hospital Insurance (Part A) _____

Medical Insurance (Part B) _____

3. SELECT A PRIMARY CARE PHYSICIAN (PCP)

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

4. 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 Specialty Plan? 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 number:	Group number:
Subscriber name:	Subscriber date of birth:

SNP Application

White copy to: UPMC for Life Specialty Plan

Yellow copy to: MEMBER

4. OTHER HEALTH INSURANCE INFORMATION *continued...*

3) Do you receive Medical Assistance/ACCESS benefits? Yes No

If "Yes," please provide your Medical Assistance/ACCESS #: _____

You must be full-dual eligible with Medicare Parts A and B and full Medical Assistance coverage at the time of enrollment to be eligible to enroll in this plan.

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* Specialty Plan? Yes No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name:

ID number:

Other coverage phone number:

Group number:

Subscriber name:

Subscriber date of birth:

5. PLEASE READ AND ANSWER THESE QUESTIONS

a) Do you have End-Stage Renal Disease (ESRD)? (ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.) Yes No

If "yes," you are not eligible to enroll in this plan unless you are currently enrolled in a UPMC Health Plan 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.

First date of outpatient dialysis: _____ Date of kidney transplant: _____

*Your answer to the following question **may** 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

If "yes," please provide your admission date: _____

Facility name _____ Facility phone # _____

Facility address _____

If "yes," you may not be eligible to enroll in this plan if your admission in a long-term care facility meets federal guidelines for institutionalized care.

(c) Have you completed this application with assistance from a UPMC Health Plan representative?

Yes, face-to-face meeting Yes, telephone call No, 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* Specialty Plan or by Medicare. **Your signature on this application means that you have read and understand the Rights and Responsibilities listed at the beginning of this form.**

Signature: _____ Today's date: _____

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

Name: _____ Relationship to enrollee: _____

Address: _____ Phone #: _____

Please return the WHITE COPY to UPMC *for Life* Specialty Plan in the **postage-paid envelope** provided. **Please keep the YELLOW COPY for your records.** Or you can fax the information to UPMC *for Life* Specialty Plan at 412-454-2973. Our mailing address is: UPMC *for Life* Specialty Plan, P.O. Box 2967, Pittsburgh, PA 15230

SNP Application **White copy to:** UPMC *for Life* Specialty Plan **Yellow copy to:** MEMBER